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An Address.[1]

THE TRAINING OF A DOCTOR.

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'Tis Education forms the common mind,
Just as the twig is bent, the tree's inclined.

ALEXANDER POPE ("Moral Essays").

THE topic of medical education is evergreen, and of continuing interest to most practitioners, whether they engage in active teaching or not. To one who has enjoyed twenty years of clinical teaching, it is a subject of the greatest importance and a pleasant change from medical politics. We have all had the closest association with at least one medical curriculum in our own experience, with many subsequent opportunities to criticize its value. Today a heavy responsibility lies upon those of us who are charged, by accident or opportunity, with discharging our Hippocratic duty in the teaching hospitals of this city. Whether one finds actual teaching to do, or more important, is a teacher at heart with an affection for and interest in the medical student and young graduate, we all share the task of seeing that, in our brief hour of teaching activity, the torch is trimmed and burning brightly, held high to dispel, as far as possible, the shadows of ignorance and obsolescence, and to cast an even illumination over the whole table of current medical lore. Progress in medical science has continued to accelerate since 1919, and no fundamental changes have taken place in the usual pattern of medical curricula. As new specialties established themselves, or new professorial chairs were created, an additional lecturer would jump on to the already overloaded academic bandwagon. The advent of the Second World War, and the necessity for medical schools to assume the role of munition factories and to train doctors as rapidly as possible, delayed any further revision of the standard medical course. The cessation of hostilities has been characterized by gross increases in student enrolment, and the current difficulty has been to expand the existing machinery to its capacity, or even further, rather than to replace it by new equipment.

There are dozens of viewpoints regarding the ideal curriculum, and it is proper and of value that each should be given a thorough hearing and even a trial, before such a vital step as the recasting of a medical curriculum is taken. This consumes a number of years, and it is a pity that the necessary discussions and experiments were not completed before the war, so that the present army of undergraduates would be better equipped for the changing order into which they are to pass.

For there is no serious criticism of the necessity for the revision of the curriculum, rather there is a world-wide recognition of the necessity for a continuing correlation of medical training with the growth of medical science. The Goodenough Committee was set up by the Ministry of Health with the direct object of examining the medical course in the light of the demands of the projected National Health Service, but at the same time seized the opportunity of a thorough criticism of the shortcomings of existing undergraduate and post-graduate programmes in the United Kingdom. It is quite apparent from a perusal of this report that our medical curriculum has embodied many of their recommendations since the advent of the Bosch Professors in the early 1930's. The Council on Medical Education and Hospitals of the American Medical Association and the Association of Medical Colleges are in the process of undertaking a comprehensive three-year survey of American medical education. My colleague, the Past-President of the Victorian Branch,

[1] Read at the annual meeting of the New South Wales Branch of the British Medical Association on March 31, 1949.

recently presented a thoughtful address on undergraduate medical education, in which he indicated some of the more important reforms immediately desirable. The Parent Body of this Association, no doubt anxious for a more independent report on the situation, set up a Curriculum Committee under the exceedingly able chairmanship of Professor Sir Henry Cohen of Liverpool. Their recommendations, under the same title as this address, were published last year in an outstanding document of 150 pages, which I sincerely commend to every tutor of any grade of medical student.

I invite you now to consider with me some of the possible ways in which young men and women may be better trained for their place as doctors in the changing order.

Pre-Medical Education.

It has been the traditional custom for intending medical students everywhere to select one or more science subjects at their matriculation examination in the expectation of surer success in these same subjects at the first degree examination. This action leads to the exclusion of more reading and instruction in the humanities, at an educational phase which can never be recaptured. Once the student enters the medical school, his time and energies are almost entirely taken up with professional studies and activities. He will rarely have another opportunity to return to a connected study of history, literature, philosophy, art or a foreign tongue. It was once a common practice for a pre-medical student to spend a year or two or even graduate in Arts before commencing the course proper, and there are few among us who do not envy such men this experience. A lengthened medical course and contemporary economics have banished this approach, but if physicians are to assume successfully positions of leadership in the community for which their professional training and status qualify them, it is essential that their knowledge should not be limited to the fields of science. Headmasters and headmistresses of secondary schools should be informed that the Faculty of Medicine desires that they should direct prospective medical students into as broad a pre-medical education as possible rather than deliberately to encourage them to spend more time on the elementary sciences. Many American medical schools demand a pre-medical arts degree prior to enrolment, and in general their college system is calculated to develop a wider knowledge of the classics than the high or great public school can provide. At the same time the college interlude acts as a buffer between the schoolboy and the medical student, a transition so abrupt in the British system. In 1224 in Salerno, Emperor Frederick II decreed three years' instruction in logic for anyone contemplating a medical career. The medical course lasted six years, including one year's practice with an experienced physician.

There are other aspects to preparation for a medical life of even greater importance, apart from those of formal education. The early development of a sense of responsibility, of loyalty, tolerance, honesty, generosity and respect for one's seniors, encourages invaluable qualities, the genesis of which must be in the home. If, in addition to these, the parents can instil or develop kindliness, curiosity, friendliness, courage and a pride in hard work, they will have accomplished their part in the education of the future doctor. The task is made more difficult in these days of small families, apartment houses, synthetic entertainment and a faster *tempo* of living. The encouragement of permanent hobbies, especially natural history, joinery, metalwork and handcrafts generally, has a long term value. One cannot escape the suspicion that doctors brought up in rural areas are frequently the most industrious and self-reliant of all. Physical education and recreation which stimulate full development and coördination of the nervous and muscular systems, and call for quick decisions and the team spirit, pay precious dividends in later professional life.

Pre-Medical Selection.

I am well aware that under the existing laws of the State any young man or woman who has attained the specified matriculation standard, and who wishes to pursue a medical course at the University of Sydney, no matter how unfitted or even undesirable he or she may be, must be accepted without further question. This situation is almost unique in the English-speaking world, and of course does not apply to even the most insignificant lay organization or fraternity. Even an office boy receives an interview before he is accepted for his post, and every gardener reserves the right to select his own seed. The existence of this state of affairs does not defend its merit or promise its perpetuation. The immediate result, for which the State must for ever accept the responsibility, may mean a great host of inadequately equipped semitrained graduates, who to a large degree, and through no fault of their own, must learn from their inevitable mistakes. The reintroduction of a compulsory intern year will help them considerably, but the consequent overloading of the teaching hospitals, and the dissipation of these men and women among small and remote hospitals, many of which will never have employed a resident medical officer before, must tend to neutralize the benefits intended. This overcrowding may disappear spontaneously, as in the past, but in the meantime the inevitable chaos must be faced bravely by teacher, student and patient. Much can and will be done by individuals to double their efforts towards maintaining and attaining a standard of which we have hitherto been proud. My contention is that it should never be allowed to happen twice, that if it threatens long term plans and adequate finance should be available to meet it, and that the public should be fully informed of the dangers, so that they can insist beforehand on a change in the existing system. The remedy obviously lies in authority for a proper pre-selection of medical students such as obtains in the United Kingdom and the United States today. With the financial barrier to entrance to medicine becoming progressively lower, and with rising costs and a teaching staff paid more adequate salaries, the contribution towards the expenses of maintaining an up-to-date medical school provided by students' fees becomes insignificant. The balance must be met by public funds or private endowment. The likelihood of the latter source is nowadays negligible. The citizens of this State therefore have a stake in their own medical school, and a right to be assured that the students under training, their own future medical attendants, are of the right basic material. The practice should be adopted here, even under present circumstances, so that the selection committee may gain valuable experience and experiment with different techniques, and while they acquaint themselves with the quality of their future students, they may even be able to dissuade certain applicants, in the interest of both the school and the candidate, from persisting with a long and costly training for which they are unsuitable. A typical selection committee consists of the dean and from two to four others, one of whom is a senior general practitioner, another a senior clinical teacher, and another engaged in medical research. All the usual personal information is available beforehand, together with reports from the last headmaster or employer, a certificate of good health, and often the results of psychological testing. The interview is friendly and informal and lasts about ten minutes. The candidate is encouraged freely to express himself, his interests, ambitions and preferences. In general an endeavour is made to assess something of the educational and family background, previous achievements, intelligence (or rather intellectual liveliness, originality and curiosity), emotional stability, perseverance, vocational sense and personality, that is, an aptitude for a medical career. The qualities sought are those found in the good general practitioner, namely, intellectual honesty, a high moral standard, and a willingness to sacrifice personal interest for that of others. These obviously cannot be properly assessed in a few minutes, even by several duplicate committees, but at least some glimmer of the suitability and desirability of the candidates can be seen. Much can be achieved by headmasters who encourage superior students only to enter medicine, particularly those with an aptitude for higher mathematics and exact science, but also those with an aptitude for biology or social sciences, always providing they have determination and character. The usual minimum age for entry overseas is eighteen years. If a schoolboy matriculates at the age of sixteen or seventeen years, he has a good opportunity to

acquire a broader cultural background by further basic learning outside science, or to undertake a year's employment in city or country, where he can emerge at his leisure from the schoolboy cocoon. But he must be careful not to drop at this stage one of his most priceless attributes, the habit of study. The signal success of ex-servicemen in competition with ex-schoolboys suggests that a short period in one of the armed forces may be almost beneficial in the end.

The Pre-Hospital Curriculum.

We come now to probably the most important phase of all, the early years of the curriculum. The delicate seedling requires precisely the right soil and gardeners of great understanding and experience, in order that the roots shall be deep and strong. On the pre-clinical teacher devolves the fundamental task of foundation building. Indifferent clinical teaching can be adjusted by lessons in practice, post-graduate reading and classes, but if the basic training has been misdirected, the loss is usually irretrievable. Adequate staff and accommodation, men of high understanding of the requirements of medical practice and of each other, with elasticity and adaptability of mind, and yet of great enthusiasm for their own important roles, as well as for their subjects, are a prerequisite for success. They must keep in close weekly, preferably daily, contact with teachers of the later years, both formally and informally, and again pay special attention to the development of the superior student, who is to shape the future medical world. In many schools, the pre-hospital departments are often geographically remote from the hospitals, whereas the whole trend, in America at least, is to have the physiological research laboratory separated by no more than a few yards from the ward.

In the first year of the medical course, surely zoology and botany must be fused again into a department of medical biology, in effect if not in actual name, the aim of which should be to introduce the student to the range, forms and phenomena of living matter, and the relationship of man to the other components of the biological spectrum. In the place of detailed anatomical and nosological discussion of lower organisms, some elements of general animal physiology, of nutrition, and of genetics and environmental influences should be introduced. Some philosophic lectures in the interdependence of man and bacteria, plant life and evolutionary trends in a mechanized, civilized world would assist the student's perspective. The medical student's education in biology, physics and chemistry should differ considerably from that of the pure scientist and form a specialized introduction to anatomy, physiology and biochemistry. The British Medical Association Committee, however, recommends that no such vocational bias should be introduced. I do not mean specifically that all that should be taught should be only that necessary for the understanding of current medical practice, but such material should receive special emphasis, and demonstrations should be arranged to show its application to medical or paramedical techniques. There is a sore need for new text-books along these lines. The British Medical Association Committee recommends that instruction in physics and chemistry should take modern atomic concepts as its starting point. As in the later years, there must be coordination in the construction of the syllabus between the teachers of the three first-year basic sciences. Before the medical student's memory of mathematics fades completely, he should have some instruction in statistics and statistical methods in medicine, in order to lay the foundation of an informed criticism at the beginning. The faculty of criticism, independent thought and frank discussion between teacher and student has reached its widest practice in America, and has great educational value. Few didactic lectures end without a free discussion period, and each teacher usually encourages his pupils to visit him at a certain hour with their own questions.

The Goodenough Committee recommends that anatomy and physiology should be taught contemporarily with physics and chemistry, but the British Medical Association Committee disagrees, for reasons which I believe to be sound on the grounds of impracticability and undesirability. I would include two or three specially arranged short optional courses in the first year, for which no examination would be held, but which are practicable only before the student enters the medical school itself, and which form an extension of his pre-medical education. Some lectures in modern languages, philosophy, political science, economics, elementary accountancy *et cetera* could be given at a suitable time by a recent graduate of the schools concerned. But whatever syllabus is followed, the first-year and second-year medical student must have sufficient free time to participate in the corporate life and recreations of his university. We need closer links with our universities than ever before, as they alone may, as history shows, remain the only green islands in a stormy sea. Medicine is not a separate entity, but exists as part of the learning and culture of the times, of which culture the universities are the ultimate guardians. This view was emphasized recently by Princess Elizabeth, and also by Professor J. C. Spence, when he placed devotion to one's university above that to school, hospital or professional association. Thus, participation in the wider culture of a university should form the broadest foundation of medical training, and such opportunities and leisure to employ them should be matters of official arrangement and encouragement. Throughout his course the student must have leisure for reflection and for the digestion of one set of facts before another set is presented to him. One further requisite—instruction and encouragement in the use of the library cannot be given too soon.

The subsequent two pre-clinical years deal with human biology—the body and mind in health—"the study of the normal". The student must be made to understand the importance of this base line or rather, basic zone, in relation to his later work, and more important still, how to integrate anatomy, physiology and psychology into the concept of the whole man. Again this is largely the responsibility of the architects of the syllabus, between whom must exist the closest liaison, cooperation and forbearance. How can the structure of the brain or heart, or the histology of the pancreas, be discussed without reference to function? Living anatomy must be presented synonymously with the appearance in the cadaver. Masses of descriptive anatomical detail are not required by the average practitioner, and are promptly forgotten. All reports agree that, even in schools without a strong surgical tradition such as our own, extensive curtailment of the traditional course in anatomy is overdue. Dissection of the whole body once, with the aid of a new manual which eliminates much of the minutiæ, is essential, and for the rest tutorial demonstrations on models, dissected specimens and living man, the latter designed specifically with an eye to the landmarks of importance in clinical medicine. Some endoscopic demonstrations of the normal appearance of the larynx, ear-drum and fundus of the eye deserve a place at this stage, while X-ray films and a fluoroscope provide further useful teaching media. A few lectures on comparative anatomy and anthropology may form an optional course. During the whole period, even with a closely dovetailed syllabus, the integration between structure and function must ultimately be effected by the student himself. The time saved by a curtailment of anatomy gives opportunities for lectures and demonstrations in normal psychology, preferably simultaneously with other studies on the brain. This consists of "psychological embryology", that is, instruction about the normal development of cognition, affection and conation in the infant and child, the general principles of instinctive activity, emotion, sentiment and behaviour, and finally the establishment of personality. Psychological speculation, theory and sub-theory are omitted, and the aim is to teach the students the psychological components and influences operative in the "normal" or average healthy individual, and those which form the basis of the subsequent doctor-patient relationship and the essential place of mental processes in the structure and functioning of a human being. Such instruction, it is recommended, should be given by a medical rather than by a lay psychologist.

Apart from a close correlation in the physiology course with anatomy, it is held that the classical syllabus for physiology lays too much emphasis on animal experimentation as compared with demonstration of human physio-

logical processes. At Harvard, medical students starve, dehydrate themselves, freeze themselves in cool chambers gasp in hot rooms or low pressure cylinders, and study many physiological phenomena on each other. Some simple frog or rabbit heart or gut experiments have real educational value, but the main emphasis on the experimental side of the course should surely be on man. Physiology and biochemistry are usually closely correlated as at our own school. Most practising physicians are trying hard to keep up with the new facts in biochemistry which have accumulated so rapidly in the last fifteen years, and while much must be left to post-graduate instruction, the student's course in biochemistry must be lengthened and elevated to an equal status with physiology. The whole of the pre-clinical subjects should be spread over two years so as to form a continuous evolutionary discipline, and no degree examinations should be held until the end of that period.

Hospital Curriculum.

Next follows the difficult transition period when the student, whether he has appreciated the significance or not of his pre-clinical factual experience, is suddenly projected into the realities, and the social and emotional texture, of a large modern hospital. From an academic consideration of the strictly normal, his work overnight becomes concerned with sick men and women preselected because they are uniformly abnormal. The student is overstimulated and over-curious. Unassisted, he finds it difficult to adjust himself to his new environment, and often casts off, for a time, consciously or unconsciously, his pre-clinical armament. The employment of junior clinicians, whom the student later meets as clinical tutors, in the physiology and anatomy departments is advocated by the Goodenough Committee. Clinicians should show patients with simple examples of disturbed physiology to physiology students, while the physiology department provides speakers and discussers at staff conferences and seminars, who may even share in systematic lectures in medicine. A short "transition course" or "orientation course" will assist in informing the student of the history and topography of the great hospital of which he is now a member, of the courtesies due to patients nursing staff, and attending medical staff, of the general aims and character of the remainder of his course, followed by some specific lectures and demonstrations on patients, designed to remind him of elementary disturbances of anatomy, physiology and biochemistry, and how use has been made of these sciences in investigation, at the same time giving an object lesson in the proper manner of approach to varying types of patients. Instruction in pathology, pharmacology, *materia medica*, and systematic medicine and surgery now begins in systematic correlation. Junior students are not allowed in the wards at this stage except under the guidance of their medical or surgical tutor, whose classes must be small enough to allow each member an individual opportunity to confirm the abnormality under demonstration.

A great responsibility devolves upon those conducting these primary bedside demonstrations in exemplifying, even in a technical exercise, their consideration of the patient as a fellow human being and as an integrated "whole man". Tutors must begin their teaching in the most elemental way, conscious that most of their class have never seen a really sick individual before in their whole lives. No reference should be made to the patient's hospital record, but the student should be taught to use his hands, eyes, ears and nose. Some nursing demonstrations by a tutor sister should be included in the fourth year. Every opportunity should be taken by tutors to point out simple lessons in applied physiology at this stage. Attendance at the casualty department should be deferred until the fifth year. From time to time senior teachers should exchange classes with their associate tutors. A close chronological relationship must exist between the professorial lectures in the principles of medicine, the classes in pathology and bacteriology, and the medical and surgical tutorials. The corresponding tutors in medicine and surgery should meet weekly for this very purpose. The early part of the didactic lectures in medicine and pathology, henceforth greatly restricted in number, should form the nucleus of the introductory course of the transition period; for example, the mechanism, expression and significance of common symptoms and signs, the causes, signs and symptoms of the common pathological processes, elementary psychopathology and social medicine and accessory aids to diagnosis.

References to specific disease entitles, differential diagnosis and treatment are misplaced at this stage. The British Medical Association Committee recommends that to counter the present divorce of pathology from clinical medicine, teaching in pathology should be spread over the whole clinical period and the clinician and pathologist should combine in the ward, laboratory and autopsy room. They advocate a month's clerkship in pathology in the final year. The committee deplores the detailed teaching of pathological, biochemical and bacteriological technique, and suggests that the living patient, not the corpse, should be the central theme in the teaching of pathology. In addition, the student should be shown examples of somatic disturbances due primarily to emotional conflict and stress, and *vice versa*. Clinico-physiological, clinico-pharmacological and clinico-pathological conferences are valuable teaching instruments to be exercised throughout the whole clinical curriculum. Pathological museums need rearrangement whereby a selected but small group of teaching specimens, illustrative of common diseases, is divorced from the rarities and curiosities. The set demonstration, in which clinical information, gross pathology and micropathology are set up together, as in Professor Boyd's museum in Toronto, is superb.

Professor Cohen's Committee recommends that pharmacology should begin, as in Sydney, during the latter half of the physiology course and continue throughout the early clinical phase, up to about half-way through what we would term fifth year. The Committee suggests that the professor of pharmacology should be responsible for instruction in *materia medica*, experimental pharmacology, and practical therapeutics, including ward demonstrations. There is room for considerable modernization in this section of the syllabus and for new text-books. The immense teaching value of the out-patient department is largely minimized by overcrowding and understaffing. It should be the feeder and the follow-up department of a specific medical or surgical unit, at which the chief of the unit also makes an appearance for consultative purposes.

I am sure the British Medical Association Committee would frown upon the total time taken up by the specialties in our own curriculum, particularly as at present they drive a wedge between the continuity of teaching in general medicine and surgery. They would also point out that our present curriculum provides 20% less lectures in pædiatrics than in gynæcology, and that long vacations cease after the third year. They would suggest a reduction of anatomy and physiology to four terms instead of five, of bacteriology from three terms to two, but would approve our introductory course in medicine and allocation of at least fifty hours to preventive medicine. The course in general medicine should emphasize the early diagnosis of diseases for which a specific remedy exists, to the exclusion of rare tropical diseases and neurological curiosities.

From the students' viewpoint, it is to be deplored that some of our best and most enthusiastic teachers forsake general medicine and surgery for one of the specialties, but, because of their enthusiasm, the content and number of their lectures must be under the continual review of the professor concerned. The educational problem posed by increasing specialization was recognized by the Goodenough Committee, and their own solution is described at length. It is doubtful whether the time spent in a busy specialty out-patient department is worth while. Three or four specially organized demonstrations of pre-selected patients would be better, the remaining practice being found in the casualty and general (minor ailments) clinic. If a new special department or clinic is formed which segregates a particular type of case, such as neuro-surgical, thoracic, orthopædic, fracture *et cetera*, either candidates for these beds must pass through the general wards, or the clinic should, at the appropriate moment, provide a pre-arranged undergraduate teaching session. The course in

pædiatrics at our own university measures up well to the standards asked for, except perhaps in preventive pædiatrics, but it should include at least three weeks' residence at the Royal Alexandra Hospital for Children, and requires a close correlation in its content with that of the systematized lectures in general medicine and surgery. Ideally pædiatrics should follow instruction in obstetrics and gynæcology.

The course in surgery is generally held to be unsatisfactory so long as it insists on attendance at operations and includes instruction in major operative surgery either in the theatre or on the cadaver. It is recommended that two appointments as dresser, both junior and senior, are desirable, the second appointment to include three to four weeks' residence at the hospital, during which time the student should also serve a clerkship in the casualty department. Instruction and practice in asepis, the surgery of minor operations, acute surgical diseases, fractures and primary traumatic surgery, and early recognition of malignant disease, have been emphasized by all writers on this subject. Films on surgical rehabilitation, occupational therapy (with a visit to such a centre), and pre-operative and post-operative care, particularly the economic consequences of surgical accidents and illnesses, are desirable. Two or three lectures from a dentist are also included.

The courses in obstetrics and gynæcology should follow each other closely in that order, at as late a stage in the clinical curriculum as practicable. The Committee recommends a two-month and a one-month clerkship respectively. There is general agreement that the long time spent formerly in instuction on the treatment of rare obstetric abnormalities should be shortened to provide more instruction in ante-natal and post-natal care, the timely recognition of abnormalities, psychological and medical complications of pregnancy, dietetics, obstetrical analgesia, and the social implications of pregnancy and labour in the home, to which the extramural practice is such an important introduction. Visits to patients' homes, after their discharge from hospital, have an important significance. Twice as much time should be devoted to obstetrics as to gynæcology. The main purpose of the practical instruction in the latter course is the pelvic examination, of which a large number should be undertaken by students on the anæsthetized subject. The relationship of social conditions, psychological problems and emotional upsets to pelvic symptoms should be taught by the gynæcologist and the link between obstetrics, gynæcology and orthopædics not overlooked.

The course in psychiatry is interwoven with the whole clinical curriculum and presents the greatest problem in teaching, partly because of the immaturity of the student and partly because of traditional disinterest, even repugnance, towards the functional. Much of this teaching must be left to the teacher of general medicine, the pædiatrician, the social worker and the teacher of social medicine. Didactic lectures in psychiatry should be very few and replaced largely by group discussions on selected patients, or even at times, on characters famous in literature or history, in which both the physician and psychiatrist could combine. The medical out-patient department is a fruitful source of material for psychosomatic consideration. The student must be taught carefully the essential elements of psychiatric case taking. In medical case taking, psychiatric investigation should be as careful and detailed as physical examination. In pædiatrics contact should be made with the parents of the sick child, and in obstetrics the mother-child relationship explored. Joint ward rounds between physician and psychiatrist deserve the warmest commendation. Special instruction is needed in the early recognition and disposal of psychiatric patients, and particularly of such psychotics and psychoneurotics as respond rapidly to physical therapy.

Social medicine, industrial medicine and public health are considered together by the British Medical Association Committee, largely because of the mutual emphasis on prevention. Social medicine is concerned with the place of the individual in his environment, and his reaction to this environment, both at home and at work. The whole group of clinical teachers have to play a part in the teaching of social and preventive medicine. The questions "Why is this patient ill?" and "How could his illness have been prevented?" should recur daily throughout the hospital epoch. Tuberculosis, rheumatic fever, peptic ulcer, diabetes, venereal disease, industrial diseases should all be approached deliberately and primarily from this angle. Socio-clinical conferences, in which physician, surgeon, public health lecturer and medical social worker all participate, are warmly recommended. Apart from the professor or senior lecturer in public health, the paramount importance of social instruction demands a specific lecturer, whose sole duty is to superintend the coordination and activities of this branch. He might be a general physician or a senior general practitioner with appropriate military or industrial experience. He could also superintend the students' health service. Lecturers in the public health course should include the city health officer and State health officers in charge of various departments, and the course should provide abundant field work, including visits with a social worker to the homes of patients awaiting admission to or recently discharged from hospital. Students must know the best and the worst of existing State and Federal health machinery.

Forensic medicine should not be over detailed, and should be adjusted strictly to the situations met with in general practice. Toxicology is best taught in the field of general medicine. A forensic museum and selected visits to the coroner's and other courts are advised. Instruction in diseases of the eye, ear, nose and throat and in venereal disease must be thorough in respect to basic principles of anatomical diagnosis rather than the minutiæ of pathological description, and special stress must be laid on the frontiers between these subjects and general medicine. There is a place for a lecturer in physical medicine who concerns himself solely with the physiology, technique, indications and limitations of physical methods, omitting descriptions of disease or details of mortality and dosage. The radiologist's most valuable contribution is the clinico-radiological conference. One or two lectures on the place of diagnostic radiology in general practice, on preparation for X-ray investigation, with illustrations, and on the scope, limitations and sequelæ of radiotherapy are approved. For the rest, sufficient X-ray evidence is presented by the general physician and surgeon.

The Teacher.

It is commonly said that medical teachers are born not made. With this I disagree. Given sufficient enthusiasm, anyone who is prepared to train himself according to the suggestions of Professor Browne of Melbourne can become a successful teacher. With a little imagination and forethought, the dullest medical subject can be made attractive by any one of us. In my view, the best technique is the Socratic question and answer method. Happily, ward teaching of the old "butterfly" variety is now largely dead. The good lecturer avoids a text-book presentation and makes no attempt to cover the whole field. He insists on basic principles, highlights the essentials of diagnosis, critically presents the current view and indicates the source of important contributions to the literature both old and new. Over-dogmatism is as evil as under-criticism. The teacher must be friendly, approachable, tactful, punctual and mindful of his own example, and almost above all, must realize his obligations to cooperation with his colleagues and the purpose of his contribution to the mosaic of preparatory medical education. But a teacher who must give most of his time to research, or who is more interested in investigative work than in teaching, should hand over most of his teaching to others.

A number of associate professors in large fields of responsibility, such as general medicine and surgery, are virtually indispensable in a curriculum such as I have described. It seems that, with a complete recasting of the syllabus, key teachers will require almost full-time appointments, and perhaps a new appointee to the staff of a teaching hospital will be required forthwith to take some special instruction in pedagogy at the university department of education. Moreover, it is obvious that the dean of a modern medical school has a full task with no time to administer a large teaching department, and it is equally patent that the faculty of medicine must designate

plenary and disciplinary powers to him as chairman of a small medical professorial board, who must build and supervise the final execution of the curriculum. The final design should be approved by a faculty quite divorced from departmental or academic interests and routine university problems.

Research.

For any student, except the "super-student", to contemplate any research in the present bulging, ill-balanced curriculum would be a physical and mental impossibility. Yet the stern dictates of any research problem, however small, the search for sources and the constructive thinking required are priceless exercises.

It is quite possible that every future graduating year will contribute a few men to a life of research. It is the serious duty of every professor to seek out, encourage and find facilities for these men to practise their first elementary problems under his guidance, and to assist in so reconstituting the medical curriculum that such exercises can be undertaken without jeopardy to the continuity of their medical course. The two-month and three-month summer recesses, which are a feature of American and Scottish universities, give staff and students their chance for refreshment, conjecture and research. I think that six weeks would be a satisfactory compromise. I often think of the mixed feelings with which Charles Best and a fellow student tossed a coin in the summer of 1921 to see who would assist a Dr. Banting with some experiments on the pancreas. The prosecution of serious research in a medical school or hospital brings a gale of enthusiasm into a teaching room or lecture theatre, which colours a speaker's voice, flutters the notebooks and awakens the sleepers. Group research has largely broken down departmental barriers overseas, and a student who, even in a very minor fashion, is part of a research team is a transformed enthusiast.

Whether a student feels drawn to an original problem or not, he must develop a sense of scientific criticism. He must learn to analyse and synthesize the clinical and laboratory information at his disposal. "He must learn to select his facts properly and form them to build up a tenable hypothesis, or else to recognise that the data are insufficient for such a step. He must assess the various components and integrate them into a mechanism that is rarely static." (Atcherly).

Examinations.

The General Medical Council commits us to the holding of examinations, whatever one's views may be. The British Medical Association Committee holds that class records should also be taken into consideration. This would mean considerably more attention to the individual student, of a degree impossible during the present overloading of our school. They are agreed that no major examinations should be held between the fourth and the final degree examinations; so that the student can absorb and integrate his study, unhampered by the tyranny of the examination hall. They suggest that the final examination consist of the three main subjects, medicine, surgery, obstetrics and gynæcology, and that no special papers be set in the specialties. Some of the questions, either in whole or in part, in the medical paper should be of the "multiple choice" type, and should include questions in psychiatry, pædiatrics, preventive medicine *et cetera*. The type of question based on a case record has much to commend it. In the view of the Committee, a man who has failed in an examination and is permitted to continue with a later course, rarely regains lost ground.

The Intern Year.

The compulsory year as a resident medical officer should ideally be conducted only in an approved hospital, such as a teaching hospital or a regional hospital in liaison with a teaching hospital, special supervision being provided. In a large teaching hospital there should be sufficient registrars to induct the new doctor into his practical responsibilities in investigation and treatment. The intern is now welcomed to staff seminars and other post-graduate exercises. At Johns Hopkins Hospital all medical interns meet weekly with the senior resident medical officer to discuss patients who have been discharged from hospital, died or been operated upon, and to agree upon the final diagnosis for purposes of classification. A special staff committee should supervise the programme and welfare of the interns. Occupation with curative medicine should not exclude a continuation of the study and discussion of preventive medicine and positive health in respect to each patient under care. The British Medical Association Committee suggests a form of internship whereby each intern would accept a patient in rotation and care for that individual in all professional respects until his or her discharge from the hospital. This system, though extremely valuable and worthy of experiment, would, in my view, be impracticable, but I can see many advantages in interns working in pairs, and each pair being attached to corresponding physician and surgeon simultaneously. The pattern of the intern's activities should approximate more closely to that of general practice, and in general it will be admitted that three months as a surgical intern and three months in the out-patient department, obstetric pavilion and reception wards would be a better preparation for the average future doctor than six months' "straight" surgery. There is something to be said for an internship at a hospital other than the hospital where the student trained. The intern should not be posted to special clinics or special wards, but he may spend some of his time at a chronic diseases hospital. Specialty departments should be saved for senior residents only. In hospitals with pavilions for private patients, the attending physician should invite his young assistant to accompany him on such a round. Time in the intern years is too precious for a large block of it to be spent in giving anæsthetics, or in the casualty department, which has definite limitations as an educational instrument. At this stage, it is far better to spend this time in the follow-up clinic, where the intern can keep in touch with the progress of his former patients. Here again, opportunities should be found for small investigations or participation in group research for those who so desire. If a relationship exists between the parent teaching hospital and a chronic diseases hospital, interns intending to enter general practice should be given the opportunity to live, say, for one month at the latter institution.

Graduate Medical Education.

Next the student passes into a phase of further training, in the general practice of family medicine, or in preparation for a clinical specialty. Only a few can remain as senior residents or acquire further supervised training at a special hospital, but annual refresher courses, particularly in obstetrics and pædiatrics, may be timed to follow the end of the annual internship, and to serve the needs of those men and women who must now enter private practice often without further supervision. General practice is a specialty in its own right and whenever possible an apprenticeship is needed. Wherever he finds himself, the graduate must continue to study if he wishes to participate in the extraordinary acceleration of medical knowledge we are witnessing today. Any general practitioner who diligently and faithfully reads the two journals which he receives as a member of this Association, will never lag far behind. I hope for the day when every general practitioner will periodically have an official liaison with a lively and progressive public hospital. Such opportunities exist widely in this city already in the form of clinical assistantships, and should be sought for by a much greater number. Failing this, or in addition, post-graduate education is provided for by the official committees, who have done a magnificent job, especially since the war. Post-graduate instruction, even from world-famous teachers, is available in plenty today, and is not yet supported in this country to the extent it should be if the Australian practitioner is to preserve his good name. It was estimated that in 1948, over 40% of all living United States physicians attended post-graduate courses. The majority of these courses

lasted five days or less. The return of alumni to their old hospitals for continuation and review courses is a popular practice in that country. Both graduate and undergraduate teaching can be arranged satisfactorily in the same institution. I am convinced that, whenever possible, graduates intending to specialize should receive at least some of their instruction overseas. This Oslerian doctrine has a special application to Australia.

I could speak at length on the place of the medical library in post-graduate education, particularly in the country. The onrush of medical knowledge is directly reflected in the rising tide of important medical literature, and here in Sydney we must plan a great medical library.

Conclusion.

1. There have been such remarkable changes in medical science during the past twenty-five years that the physician is no longer competent merely on the basis of his familiarity with certain basic patterns of disease. A working knowledge of the basic medical sciences must play a practical role in his daily study of patients. With the increasing accent on preventive medicine, in all its facets, there is a call for a complete revolution in medical training. The curriculum must be so orientated and coordinated as to portray the synthesis of man's various dynamic units into a total functioning organism. The graduate must go forth from his medical school equipped with a scientific critical attitude and drive, and with an understanding of the background as well as the foreground of both health and disease. The aim of the undergraduate medical curriculum is no longer to turn out a competent general practitioner at graduation. Rather it should be a training in the basic principles of medical art and science as a foundation for all forms of medical practice.
2. The most important of many blueprints for a new curriculum, which plans for all these requisites, is that prepared in 1948 by a committee of the Parent Body. In a satisfactory medical curriculum, time must be available for healthy exercise and recreation and for independent reading and leisurely reflection.
3. The cost of the plans outlined in men and material will be high and must become a national responsibility. Our Association's future is vitally linked with the equipment of its future members with the highest standards of ethics and technical practice. I suggest that our own Federal Council should form its own medical curriculum committee with the British Medical Association Report as its text-book, that an Australian association of medical teachers should be inaugurated, and that THE MEDICAL JOURNAL OF AUSTRALIA should publish an annual Education Number.

"Those who cannot remember the past are condemned to repeat it."—George Santayana.

CHILD PSYCHIATRY.[1]

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THE invitation to address this meeting of our Association on the subject of child psychiatry has naturally given me great pleasure, but has also been a stimulus to considerable thought and mental stocktaking of a not wholly satisfactory nature. It is now nearly twenty years since I was appointed psychiatrist to the Children's Hospital, Melbourne, and during this twenty years there have been tremendous changes in this field of work. It is true that before this time there had been some pioneer clinics, such as that of William Healy in Chicago, and that the child guidance clinics had been increasing in number in the United States of America and the United Kingdom. There was, however, still considerable ignorance regarding the work and techniques of such clinics.

Some work had been done in Victoria by Professor R. J. A. Berry and members of the Education Department in the investigation of intelligence tests and the possible correlation of the results of these with constitutional factors. Some of this had been carried out at the Children's Hospital owing to the interest of Dr. H. Boyd Graham.

In the years that have passed there has, of course, been a tremendous advance in the number of child guidance clinics, and in Victoria clinics have been established in connexion with the Department of Health and the children's courts. The clinic at the Children's Hospital has shown considerable growth and, whereas it was confined to myself and a psychological tester, the staff now includes five part-time psychiatrists, three part-time psychologists, one full-time psychiatric social worker, three full-time speech therapists, two full-time and one part-time play therapists, one part-time tutor, one part-time audiometrician, and clerk and receptionist (full-time), with approximately 130 attendances per week. Instead of part-time use of two rooms we are now in full-time occupation of a commodious villa of nine rooms with "all mod. cons.". This growth obviously requires explanation and perhaps excuse. One explanation is the increased growth of interest in child health in all aspects, but a further explanation is the great degree of specialization that has occurred. The classical child guidance team consists of a psychiatrist, a psychologist and a social worker, and the work of each of these has shown great advances. The psychologist is no longer content with the Binet-Simon scale, but has an armamentarium of numerous other tests of intelligence, as well as projective methods, such as Rorschach and thematic apperception, and the report of the psychologist no longer consists of an intelligence quotient, but of some analysis of the intellectual equipment as well as suggestions regarding emotional attitudes and educational placement. The social worker has evolved from an almoner collecting fees and making appointments to a university graduate with a training to equip her for adequate investigation of emotional backgrounds and ability and willingness to attempt their modification. This often means quite intensive psychotherapy with the parents. There have also been great advances in speech therapy and techniques in audiometry.

A comparatively recent development has been seen in the work of the play therapists, whose work consists in observing and perhaps guiding the play of children when faced with the usual facilities of a playroom. As part of this work there sometimes arises the need to analyse products of play, such as painting, modelling and general behaviour, and this work is regarded as of such significance that in many clinics it is regarded as the proper role of the psychiatrist, who therefore spends his time being maltreated by the young and making analyses of products of the child's unconscious, as shown in play. However, pressure of time and shortage of staff often mean that this work is relegated to someone of non-medical training, such as psychologists or kindergarteners.

The mode of work in clinics varies considerably. In perhaps the majority of clinics the initial interview with the parent and child is the work of the social worker, who takes a preliminary history and may arrange for intelligence tests and home visits, if these are indicated, and then presents her statement of the problem and test findings, and the child, to the psychiatrist. His main work is the interview and examination of the child and the giving of advice to social worker and parent regarding adjustments of emotional attitudes, scholastic placement, and other aspects of the environment. In addition, direct psychotherapy may be required, and this is often carried out in the atmosphere of a playroom. In other clinics the initial interview is with the psychiatrist, who endeavours to interview child and parent separately, as well as together, and then decides on what further tests, investigations or treatment are desirable by the psychologist or social worker. The role of the psychiatrist may drift into the background in some clinics where problems of

[1] Read at a meeting of the Section of Neurology and Psychiatry, Australasian Medical Congress (British Medical Association), Sixth Session, Perth, August, 1948.

educational placement are mainly dealt with, and only those children thought to require special psychiatric investigation are referred by the psychologist in charge to a psychiatrist, who acts as consultant. In others again the psychiatrist may be regarded as wholly unnecessary, and a pædiatrician to investigate the physical state is all that is thought necessary.

From this survey it seems that some questions of quite considerable importance arise. First, what problems, if any, of the child's conduct, habits or personality are to be regarded as coming within the sphere of the psychiatrist? Secondly, what part is he to play in the investigation and treatment of these problems? Thirdly, what preparation is required to fit him for an active role in the treatment of these problems? Fourthly, is he prepared to admit others to responsibility for the care of these children?

The answers to these questions are not simple, and it is obvious that there are workers in many other fields who are greatly concerned with these problems and who take responsibility, whether we like it or not, for their treatment. Such workers are to be found particularly in the field of education, but it is obvious that many perplexed parents and their kindly or malicious neighbours, as well as the family practitioner and pædiatrician, all take their share in treatment as well as in diagnosis. Much of the pioneer work has been carried out by such non-medical authorities as the late Dr. Susan Isaacs and Professor Cyril Burt, and the latter has stated that "the problem of child guidance is not so much clinical or medical but psychological". If we are to compete successfully, we must, it seems, have more to rely on than the doubtful prestige of the word psychiatrist, and there is no doubt that often there is little in our training to fit us for leadership in this field.

Classification of Material.

Some of the material coming to a child psychiatric clinic may be classified according to the generally accepted classifications of adult disorders, that is, psychoses, psychoneuroses, psychopathic states and mental defects. In addition, we generally include a group of primary behaviour problems as well as a group of behaviour problems secondary to organic disease — for example, trauma, encephalitis and toxic states. While it is impossible to deal with these in detail, it seems desirable to point to some characteristics of these groups as seen in children, for they differ in many ways from those in adults.

Psychoses are generally regarded as rare, but it is possible that they may be more frequent than is commonly thought, owing to lack of recognition of a psychotic process underlying oddities of behaviour. It is thought that some cases of retardation of development and apparent mental defect may result from an early schizophrenic illness. The fully developed schizophrenic psychoses of childhood have been variously described, but all seem to be rarities, and manic-depressive psychoses are even more so, according to most authorities, though here again the variability of mood characteristic of childhood may lead to minor manifestations of the cyclothymic disorder passing unrecognized. Acute toxic deliria are relatively common and generally carry a good prognosis, but there is an interesting group of behaviour problems secondary to organic brain damage that may be regarded as the counterpart of the organic psychoses of adult psychiatry. These may follow encephalitides of virus origin, such as *encephalitis lethargica*, measles, whooping-cough and varicella, as well as pyogenic infections and burns. They also follow traumata at birth or later, and there appear to be good grounds for considering prematurity as an important predisposing factor. There is some discrepancy in views as to prognosis, but opinion is now far more optimistic, provided that treatment takes into account the emotional and social background. After *encephalitis lethargica* there seems to be definite dementia in many cases, and the same may occur after pertussis.

The field of mental defect and retardation is very wide, and the role of minor grades of defect in the causation of behaviour problems requires stress. It appears to be definite that if the condition is diagnosed and the patients are given satisfactory management in home and school, many of them are capable of satisfactory routine work, but if they are allowed to drift through the ordinary school the difficulties in the way of a satisfactory adjustment are greatly increased. Lack of understanding of their limitations on the part of parents, teachers and employers must lead to trouble, often of a delinquent nature.

Recognition of the importance of the Rh factor and of maternal rubella has served to arouse interest in pre-natal conditions leading to mental defect, and recent work on vitamin deficiency in the pregnant mother may also be mentioned in this connexion. The role of sensory defect appears to have been largely overlooked in the past, and it seems that the rubella cases have been of value here also in emphasizing the need for a satisfactory audiometric technique in the examination of young children. It seems that in the past many partially deaf children have been erroneously regarded as defective. The confusion in the mind of a child with high tone-deafness must be very difficult to overcome.

The plight of the spastic child has recently roused public interest, which has been intensified by the visit of Dr. Carlson to this country. It seems desirable to stress the fact that the majority suffer from intellectual defect and that an appraisal of the abilities at as early a stage as possible is very desirable. This presents many difficulties, but is essential if false hopes are not to lead to profound disappointment and wasted effort.

Anxiety states of minor degree are extremely common and may occur very early with a fear of the unknown, which may be the result of communication from an over-anxious parent. They may also arise later as a result of intellectual over-stimulation or the lack of a satisfactory intellectual outlet. This has been emphasized by William Moodie, who states that in these cases of generalized anxiety there tends to be an emphasis on physical disorders, such as sweating, vomiting, enuresis, twitching and exaggerated reflexes, as well as tachycardia, giddiness, diarrhœa and indigestion. There is often an associated acidosis and a refusal of school, which may be quite a difficult problem.

If, on the other hand, the anxiety arises as a result of emotional frustration or over-stimulation, the anxiety tends to be more defined, with more specific fears, sometimes with obsessional characteristics, such as of sickness or of death of parents. Sometimes the anxiety is hidden and replaced by outbursts of temper, aggressive behaviour, feelings of guilt or delinquent behaviour.

Obsessive-compulsive states of minor degrees are quite common and more severe degrees also occur. There may be recurrent doubts, scruples or images of the past with ritualistic behaviour, such as hand-washing and tics. Fully developed somatic hysterical syndromes, for example, blindness, aphonia, paralysis, are rather infrequent, but complaints of pain, lack of appetite, vomiting, enuresis, stammering and tics often appear to be hysterical in nature, with suggestion and a desire for sympathy, self-assertion or evasion of difficulties playing a part.

Many behaviour problems do not, however, bear the stamp of neurosis as generally understood. Some appear to be the result of psychopathic constitutions, and the classification of these presents great difficulties. They are of considerable importance, as those affected are sometimes predisposed to psychosis, for example, the odd, queer and peculiar, as well as the shy, backward and passive, the aggressive and the obstinate. How far these are to be regarded as the results of early phases of a schizophrenic illness or a congenital predisposition to such an illness is uncertain.

Other problems appear to result from faulty handling in infancy, with insecurity, aggression, anxiety and guilt, and here we find the habit disorders, thumb-sucking, hair-pulling, nail-biting, masturbation, as well as the condition of the "naughty" child with temper tantrums, food fads, truancies and delinquencies.

Last, but not least, should be mentioned the problems associated with epilepsy and the light thrown on these

and other disorders by the electroencephalogram, and the possibilities of correcting behaviour by suitable drugs to control the faulty cerebral activity.

Causation.

The causation of this variety of disorders varies widely, but all are due to a failure to develop a balance between instinctive drives and environmental demands of such a kind that the welfare of the individual and society is assured. How far this failure is due to inherited traits or congenital defects, as in most mental defectives, or to temporary or permanent bodily ill health, or to infantile psychic traumata at some stage from birth through weaning and habit training and the normal severance of parental bonds, or to later stress associated with schooling or the strain of puberty, is often impossible to assess. Are we to assume that there are inborn defects of instinctive and intellectual equipment that condemn the individual to the development of difficulties and frustration and later psychiatric disabilities, or are we to assume that early frustration at the breast or during habit training is so likely to be harmful that it is essential for these to be ventilated in later life via analysis, if the individual is to have a chance of satisfactory adjustment? Are we, on the other hand, to believe that a satisfactory régime in the present with a full measure of satisfaction of emotional needs, such as love and security and a sense of achievement, will eradicate the evils of early mistakes?

No one of these assumptions can be regarded as exclusive of the others. As an example of this we may take the over-anxious child of the over-anxious parent and endeavour to distinguish between the inheritance of such a characteristic and the effect of unconscious "introjection" as well as conscious imitation. Here, as elsewhere in psychiatry, one has to adopt the aim of a comprehensive survey of the whole situation—the child with its inherited potentialities and the influences responsible for aiding and hindering the development of these. This having been done, it is our task to remove difficulties in the way of a satisfactory adjustment and to see that all possible aid is given to achieve this.

Treatment.

To remove the difficulties mentioned and to ensure all possible aid we must have some knowledge of the mental development of the normal child, with its growth from a being with only a helpless cry to show discomfort, with undifferentiated sensations and primitive emotional displays, but with considerable urgency of feelings and wishes, fears and angers, loves and hates, till it reaches the stage of a normal adult.

Psychoanalytical views as to the stages passed through are accepted by many, and it is stated that confirmation can be obtained from observation of play and the phantasies disclosed in this way. Difficulty of interpretation then arises, for if we are to assume, for example, that every drawing of a ship symbolizes the maternal womb and that playing trains symbolizes sexual intercourse, our interpretations are likely to have a sexual bias. There seems, however, to be little doubt that in the constant struggle between instinctive needs and the environment tension is generated with manifestations of emotions of many kinds. Such tension is most likely to arise in certain circumstances, such as weaning, the arrival of another sibling or admission to school, as well as resulting from faulty handling of habit training by over-anxious parents and grandparents. If release from tension can be obtained by the working out of phantasies via play and imaginative artistic efforts, development will proceed far more satisfactorily than if this is allowed to continue with resulting repressions, dissociations and other psychopathological mechanisms. Similarly, if at a later stage we find tension resulting from frustration at school, it is obvious that proper placement and tuition may go far to remedy this and to give that satisfaction in achievement which is such a fundamental need throughout our development.

The correction of psychiatric disorders in childhood would be expected to reduce the liability to adult disorders, but there is little statistical proof that such is the case, and it is doubtful whether such proof can be obtained without far more investigation of control series and experimentation than have been carried out to date. However, some traits of personality may be traced to persistence of childish characteristics into adult life, and there is evidence that these are at any rate not wholly inherited, but acquired wholly or in part, and that they may be modified by suitable experience, as in a play group, or by analytic procedures. Their persistence is regarded as tending to adult psychiatric disorders. If this is true and if we psychiatrists are interested in facts of development as well as in the latest shock box, it seems that interest in child psychiatry should be universal amongst us.

We may therefore answer the first of the questions, that is, what problems, if any, of the child's conduct, habits and personality are to be regarded as coming within the sphere of the psychiatrist, by stating that all such problems are of psychiatric interest, but particularly those pointing by reason of their severity, oddity and duration to disorders of personality rather than to the temporary faults inevitable in the process of growing up. Without some practical knowledge of these minor problems we are, however, unfitted to advise and treat the more severely affected.

Training and Education.

The second question as to what part we are to play in the investigation and treatment should, it seems, be answered by saying that we should be capable of leadership and direction of others—by reason of a breadth of vision and experience likely to be lacking in others without medical training, but it is essential for this to be combined with knowledge of the fields of work covered by those others and for us to be at least able to discuss psychological and play techniques and to realize the difficulties inherent in the case work of the psychiatric social worker and the treatment of speech disorders.

It may not, of course, be possible or advisable to work in clinics, and much consultant work is an individual affair, but even here an appreciation of the help to be obtained by special techniques is of considerable value.

With the recent developments in psychological training it appears that ex-cathedra statements of a psychiatrist or neurologist, together with the prescription of sedatives, are no longer sufficient, and this brings us to the third question as to the preparation required to fit us for an active part in the treatment of children. Although the psychological side has been stressed, it is apparent that problems of bodily disorder are frequently present, and it is our knowledge, real or imaginary, of such disorders that has given us a claim to leadership in this field in the past. The role of biochemical, endocrine and infectious factors in the causation of psychiatric disorders still requires much research, but there is evidence that emotional factors are responsible for much psychosomatic disorder, such as constipation, enuresis, obesity, anorexia, and so on. For these reasons sound pædiatric training is to be regarded as at least very desirable if pitfalls are to be avoided. Otherwise pædiatric advice will often be necessary.

It is often stated that a personal analysis should be regarded as a *sine qua non*. As I have not been analysed my views on this are not quite in accord, but it does seem that insight into the child's mind must be obtained by careful observation and experience if mistakes are not to be made too freely. Without such insight, emphasis on the symptoms may lead to neglect of underlying emotional disorder. An analysis may give the necessary insight, but the acceptance with a religious fanaticism of the dogma of the training analyst is not to be regarded as a guarantee of scientific objectivity. The claims of satisfactory results of the analysis of children with the rigid sexual interpretation of symbolism in behaviour are not to be regarded as proof that these are correct interpretations. They may rather be regarded as particularly impressive fairy tales. Prolonged and intensive experience of "normal" children's behaviour is difficult to obtain outside of kindergartens and school, but it is nevertheless

very desirable if symptoms are to be seen in their proper perspective.

Leadership and Cooperation.

The fourth question as to willingnes to admit others to responsibility for care and treatment must be answered in the affirmative, for the tremendous bulk of work in such fields as education of the handicapped by reasons of physical or mental defect, the cure of speech defects and delinquency, as well as the common disorders of habit and personality, far exceeds the possibility of adequate treatment by very many times our number.

Though we may and should lead in treatment and in the provision of community facilities for prophylaxis and treatment, such as reasonable educational measures for all, however handicapped, and suitable facilities for play and recreation, we cannot direct the education or the play of all, and the cooperation of others must be sought. The leadership in this field by our profession is often disputed, and it is quite useless for us to assert our claims unless we can support them by knowledge widely spread throughout the profession as a whole and by increased numbers of specialists within the profession. The approach to the problems of the individual as those of a being with mental and physical qualities constantly being adjusted to an environment bristling with possibilities of a harmful nature—nutritional, microbic and emotional—has been the main plank of our psychiatric platform for many years past. This approach is now becoming more widespread, and lip service to the role of emotional factors and "psychosomatic medicine" has become popular. Nowhere in medicine does it seem that this approach is so necessary or helpful as in the study of children. Unfortunately little is being done in this regard, and many opportunities are being neglected. The role of the doctor in such important fields of work as baby health centres, kindergartens and schools appears often to be limited to bodily care. Important as such problems undoubtedly are, it is a matter for considerable regret if, in the medical services of such organizations, the role of emotional and intellectual factors in causing maladjustments and ill health should be neglected or left to the investigation and care of non-medical personnel.

The growth of child guidance clinics in Great Britain has already been mentioned, and we are lagging far behind in this country. It is to be feared that any advance in the numbers of clinics here would reveal a great lack of psychiatrists qualified to direct them. In my opinion, prejudiced as it may be, the lack of this medical direction is decidedly unfortunate, and this paper is to be regarded as a plea for more attention to the study of child psychiatry, not only for the interest attaching to it, and not only for the contributions to the knowledge of adult disorders which should result, but for the welfare of the children of the community. Some need intensive investigation by specialized techniques, but in the great majority of cases "informed common sense" on the part of the general practitioner, school medical officer and pædiatrician will be sufficient. However, the common sense must be well informed, and unfortunately lack of information or faulty information is only too common.

EOSINOPHILIA IN ALLERGY.

By T. D. ORBAN,

From the Allergy Clinic, Newcastle Hospital, Newcastle.

EOSINOPHILIA is usually quoted as being due to three main causes: helminthiasis, extensive skin diseases and allergy. The eosinophilic tissue response is easily detected in the peripheral blood, but no information is available in standard text-books on the usefulness of eosinophilia as a diagnostic aid for allergic diseases.

This investigation was undertaken in an attempt to establish the relability of eosinophilia as a diagnostic aid in allergy.

Materials and Methods.

Two hundred consecutive patients attending the allergy clinic at Newcastle Hospital were investigated. These patients were referred from outside practitioners and from the various out-patient departments of the hospital. Although the diagnosis of allergy was not tenable in all instances, no cases have been eliminated from the 200 consecutive new cases reviewed.

A single estimation of a total and eosinophile white cell count was performed at the patient's first attendance. No attempt was made to discover causes of eosinophilia other than allergy; but it was deemed unlikely that the incidence of these other causes (helminthiasis or skin disease) would be greater in this group than in the general population, which in 200 consecutive out-patients attending the hæmatology department for miscellaneous ailments was 9%.

TABLE I.

	Total Subjects.	Eosinophilic Subjects.	Percentage.
Asthmatics.			
Asthma only	82	79	96
Asthma and hay fever	38	32	84
Asthma and angioneurotic œdema	2	2	—
Asthma and hives	3	3	—
Asthma, hay fever and hives	1	1	—
Total	126	117	93
Non-Asthmatics.			
Hay fever	41	25	61
Angioneurotic œdema	2	1	—
Urticaria	5	3	—
Hay fever and angioneurotic œdema	5	4	—
Hay fever and migraine	2	2	—
Hay fever and hives	2	1	—
Angioneurotic œdema and hives	4	1	—
Migraine and hives	2	0	—
Hay fever, angioneurotic œdema and migraine	1	0	—
Total	64	37	58
Probably Not Allergic.			
Bronchitis	2	0	—
Cardiac asthma	1	0	—
Neurosis	1	0	—
Conjunctivitis and cyclitis (*? keratitis rosacea*)	1	1	—
"Cold"	1	0	—
Nasal polypi	1	0	—
Dermatitis	1	1	—
Premenstrual tension	1	0	—
Total	9	2	—

The white cell counts were carried out with a modification of the wet chamber technique described by Randolph.[1] The diluting fluid was made up of two solutions, *A* and *B*, mixed in equal proportions just before use. Solution *A* consisted of brilliant cresyl blue, 0·1 gramme, and propylene glycol, 100 millilitres. Solution *B* consisted of eosin W. gelblich (Grübler), 0·1 gramme, and *aqua destillata*, 100 millilitres.

Capillary blood was collected in a white cell pipette to the 0·5 mark and diluted to the 11 mark with this diluting fluid. The pipette was allowed to stand for at least fifteen minutes to allow time for staining of the eosinophile cells and fading of the red blood cells before flooding of the counting chamber. After being flooded the chamber was allowed to stand for three to four minutes to allow for settling of the white cells before the counting. The high viscosity of the propylene glycol

necessitates the longer time required for the settling of the white cells.

The total white cell count and eosinophile count were then carried in a single step. This method does away with the need to prepare stained blood film preparations.

Results.

It is stated by Whitby and Britton[2] that the absolute eosinophile count is a better indication of eosinophilia and is preferable to the use of the relative percentage of eosinophile cells as usually expressed in a differential white cell count. Accordingly in all cases "eosinophilia" signifies an absolute eosinophile count of 400 per cubic millimetre or higher.

Out of the total number of 200 patients, 156 showed eosinophilia—that is, 78%. In Table I these 200 patients are grouped according to the nature of their disease.

Comment.

It is evident that the occurrence of eosinophilia is dependent upon the nature of the disease and shows considerable variation even though these diseases are all classed as allergic.

With regard to the initial purpose of this investigation, it is perhaps fair to state that eosinophilia as a diagnostic aid does not fall far behind other laboratory investigations in its reliability, particularly for the asthmatic group of allergies.

Conclusions.

1. If a standard of 400 eosinophile cells per cubic millimetre is used, eosinophilia is a useful diagnostic aid in allergy.

The production of an eosinophilic response appears to depend on the nature of the organ involved in the allergic reaction.

Summary.

A series of 200 consecutive patients attending the allergy clinic of Newcastle Hospital has been investigated from the point of view of the incidence of eosinophilia. A rapid technique for the performance of differential white cell counts, a statistical analysis of the results and the conclusions drawn therefrom have been described.

Acknowledgement.

The technical work was carried out by Mr. K. O'Sullivan, of the pathology department, Newcastle Hospital.

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(1) T. G. Randolph: "Differentiation of Leucocytes in the Counting Chamber by Propylene Glycol-Aqueous Stains: A Screen for the Detection of Major Blood Abnormality", *American Journal of Clinical Pathology*, Technical Section, Volume VIII, 1944, page 48.

(2) L. Whitby and C. J. C. Britton: "Disorders of the Blood", Fifth Edition, 1946.

Reviews.

MARRIAGE COUNSELLING.

"MARRIAGE COUNSELLING" is the first full account of the remedial work of the Marriage Guidance Councils of Britain.[1] The objects of the councils are to "build sound unions" and if possible "to mend broken ones". Prevention is better than cure and it is considered that pre-marital education is of first-rate importance; advice and education for those about to marry are provided at the centres. The complete confidence of the public is essential to success and is enjoyed by the councils. For this reason the case histories recorded in the book are strictly limited. The need for counselling, what the centre must offer, the diagnosis of marital disharmony, the treatment of marital disharmony, marriage consultants, some ethical questions, why marriages go wrong, are some of the subjects of the chapters. Marriage counsellors are selected on broad general principles, and individual patients are referred to doctors at their professional rooms. However, a preliminary "sorting out" is done to ascertain amongst other things whether each spouse is cooperating. In the case of one spouse refusing to cooperate the counsellor writes to him or her; specimen letters used in such cases are given in full. One cannot but be struck with the vein of common sense running through the methods employed. The strictest critic could not be offended by the approach adopted with its scientific background, nor with the methods suggested for dealing with such thorny problems, nor could any charge be laid of evading the issues involved. Each marriage has an individuality of its own, and must be considered on its own merits or demerits. The importance of the response to sexual union on the part of husband or wife is emphasized as a factor in diagnosis and treatment. The elusive problems of consideration for the other spouse, or lack of it, cannot be classified into tidy categories. An extensive list of the crises and emotional disturbances likely to arise in any marriage, from lack of knowledge, as well as during the various time phases, up to that when full-grown children leave home, is dealt with. As regards parenthood the golden rule is that procreation should always be the result of mutual desire and deliberate—a consideration so often apt to be omitted from the philosophy of the well-intentioned adviser. This admirable book is full of human understanding of the difficulties faced by the unfortunate victims of unhappy marriage.

[1] "Marriage Counselling: The First Full Account of the Remedial Work of the Marriage Guidance Councils", by David R. Mace, M.A., B.Sc., Ph.D., with a foreword by the Rt. Hon. Henry Willink, M.C., K.C.; 1948. London: J. and A. Churchill, Limited. 7¼" × 5¼", pp. 184. Price: 8s.

HERNIA.

"HERNIA", by Leigh F. Watson, is a book which sets out to describe every hernia that occurs in the human body.[1] From the point of view of review the contents of the book can be divided into three parts.

The first deals with rare herniæ. A complete and authoritative account is given of such rare herniæ as sciatic hernia, obturator hernia, lumbar hernia, internal hernia *et cetera*. The author has evidently had a vast personal experience and he states his own opinions with no uncertain voice. It must be remembered that the average surgeon will see perhaps only one of these rare herniæ in a lifetime, and it may then be unexpectedly, so that it is very necessary that there should be close at hand for quick reference such as a book as this.

The second part deals with the injection treatment of herniæ. No less than 60 pages are devoted to this subject. This will probably seem extraordinary to the Australian surgeon, but it must be remembered that there appears every now and then a patient for whom any sort of operation is inadvisable. As the injection treatment if properly carried out is curative it is obvious that this is much more desirable than the wearing of a truss.

The third part deals with the inguinal herniæ. It is to this section that the ordinary surgeon will turn with most interest, as he is constantly dealing with this type of hernia, particularly if it is of the indirect type. It must be stated at once that as far as indirect inguinal hernia is concerned we disagree with the author. The author belongs to the school apparently very common in America which believes that except in children indirect inguinal hernia can be cured only by an extensive operation, the preliminary to which is a wide dissection of the whole inguinal canal. He disregards the school which believes in local operation only. Those who believe in the extensive plastic operations derive their authority from Bassini in Europe and from Halsted in America. In carrying on the tradition of these great surgeons, however, they have overlooked one important factor, and that is that there is a very great change in the condition of patients presenting eighty years ago and today. It is obvious from their reports that Bassini and Halsted were accustomed to dealing with long-standing herniæ which had enlarged until they had virtually become direct herniæ. Since that time the population has become operation-minded and it is very rare to see herniæ of that type. When the adherents of this school are asked why they practise an extensive dissection of the whole canal when the part affected is at the lateral end of the canal, they reply that it is because the most common recurrence is a direct one. When it is pointed out to them that this direct recurrence may actually be due to the operation itself, they have to

[1] "Hernia: Anatomy, Etiology, Symptoms, Diagnosis, Differential Diagnosis, Prognosis, and Treatment", by Leigh F. Watson, M.D., F.I.C.S. (Los Angeles); Third Edition; 1948. St. Louis: The C. V. Mosby Company. Melbourne: W. Ramsay (Surgical) Proprietary, Limited. 9½" × 6½", pp. 736, with 323 illustrations. Price: £5 1s.

reply, if they are honest, that there is no evidence to show whether this is the case or not. For the fact of the matter is that the extensive research work necessary to prove or disprove this point has never been carried out. The surgery of hernia, in fact, unlike what obtains in most other branches of surgery, does not rest on any sound basis. When therefore we find that the author of such a book as this recommends as the standard operation for indirect inguinal hernia what is known as the Cooper's ligament operation, we feel that the young surgeon must be warned that he should study also the writings of the English school who strongly advocate the local operation.

There are chapters also on the "Truss Treatment" and on "Industrial Hernia". At the beginning of each section there are excellent historical notes and at the end of each section a complete bibliography. The historical notes and the bibliographies alone make the book worth buying. As is usual with American books, the production is magnificent. This is a book for every library.

ARTIFICIAL PNEUMOTHORAX IN PULMONARY TUBERCULOSIS.

THE publication of the second edition of "Artificial Pneumothorax in Pulmonary Tuberculosis" by T. G. Heaton is timely in Australia, in view of the recent greatly increased interest in its subject.[1] The author covers his subject fully, and although one might not be in complete agreement with all his statements concerning the indications for artificial pneumothorax, its management and its relationship to other forms of treatment, and especially surgical treatment, one is impressed by his evident first-hand knowledge and by his knowledge of the experience of others. As in most publications on the treatment of pulmonary tuberculosis, the lack of statistically acceptable figures of results is noticeable. Nevertheless, the value of the treatment is apparent in what he writes and quotes.

It is felt that, allowing for differences of personal opinion, the beginner should not accept all that is stated without question. For example, although the value of rest is emphasized by the author, the induction of artificial pneumothorax in acute disease should not be attempted "early" without sufficient bed rest. It is questionable if inoperable adhesions will form in a delay of three months for bed rest. Further, although the danger of adhesions is stressed, there must be few men experienced in the use of the thoracoscope who would agree that only those "easily" cut should be divided. The hazards of the operation are over-emphasized, and this confirms an impression that internal pneumonolysis is more efficiently performed in Britain than it is in North America. It is also surprising to note that sedation is recommended before the induction and apparently not uncommonly before refills, and that, further, local anæsthesia is recommended for refills.

The term "sputum conversion" is used loosely. What is meant by "positive" or "negative" sputum? No indication is given of the number and frequency of sputum examinations necessary before the patient may be labelled "negative". The concentration method is stated to be preferable, but how many workers would agree that "inoculation or culture methods, especially the culture of gastric contents, are probably unnecessarily delicate"? No mention is made of the guinea-pig.

The author's views on the treatment of empyema are sound, except that he appears too reluctant to advise an early thoracoplasty. Most physicians would agree that "it is not clear whether any irrigating fluid is better than saline". His advocacy of oleothorax in some cases would not receive much support in this country.

The chapters on history, intrathoracic dynamics and pathology should prove interesting to all students of the subject. Those on pathology and mode of action do not give us much more certainty than we had before, although this is not the author's fault. His stressing of the importance of accurate estimation of respiratory function is to be welcomed, as this aspect of the control of artificial pneumothorax and other collapse measures is sadly neglected in this country. His emphasis on the potential gravity of the minimal lesion is welcome.

The text is well written and easy to read. Such a book, by an author who knows his subject, can be warmly recommended to all interested in the treatment of pulmonary tuberculosis.

[1] "Artificial Pneumothorax in Pulmonary Tuberculosis", by T. G. Heaton, M.B. (Toronto), with an Introduction by Dr. C. D. Parfitt; Second Edition; 1947. Toronto: The Macmillan Company of Canada, Limited. 8" × 5½", pp. 312. Price: 20s.

Books Received.

[The mention of a book in this column does not imply that no review will appear in a subsequent issue.]

"Humanism as a Philosophy", by Corliss Lamont; 1949. New York: Philosophical Library. 8½" × 5½", pp. 376. Price: $3.75.

Described by the author as a philosopher's testament.

"Pathology of Tumours", by R. A. Willis, D.Sc., M.D., F.R.C.P.; 1948. Sydney and London: Butterworth and Company (Publishers) Limited. St. Louis: The C. V. Mosby Company. 9½" × 6¼", pp. 1126, with 500 illustrations.

Addressed primarily to pathologists, research workers and senior students and based on the author's own observations and conclusions.

"Sex and its Mysteries", by George Ryley Scott, F.Z.S., F.Ph.S. (England); Second Edition; 1949. London: Torchstream Books. 8½" × 5½", pp. 218. Price 12s. 6d.

Intended for responsible persons who wish to acquire the facts about sex.

"Lawson Tait, 1845-1899", by I. Harvey Flack, M.D.; 1949. London: William Heinemann (Medical Books), Limited. 7¼" × 5¾", pp. 162, with 12 illustrations. Price 17s. 6d.

An expansion of the Thomas Vicary Lecture of 1947.

"Evolution of the Forebrain: The Fundamental Anatomy of the Telencephalon with special reference to that of Testudo geometrica", by G. W. H. Schepers, D.Sc., M.D.; 1948. Cape Town: Maskew Miller Limited. 11" × 8¼", pp. 228, with 250 illustrations. Price 50s.

"A monographic treatment of the fundamental problems involved in the telencephalon."

"The Surgical Clinics of North America" (issued every two months); 1949. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical) Proprietary, Limited. Chicago Number. 8¾" × 5¾", pp. 316, with 143 illustrations. Price: £5 10s. (cloth binding) and £4 12s. 6d. (paper binding) per clinic year.

Consists of a symposium on orthopædic surgery by 22 contributors. It is a "Chicago Number".

"Cardiovascular Disease in General Practice", by Terence East, M.A., D.M. (Oxon), F.R.C.P. (London). Third Edition; 1949. London: H. K. Lewis and Company Limited. 8½" × 5½", pp. 222, with 34 illustrations. Price 15s.

Intended for use at the bedside by the general practitioner.

"Early Recognition of Disease", edited by Sir Heneage Ogilvie, K.B.E., D.M., M.Ch., F.R.C.S. and William A. R. Thomson, M.D.; 1949. London: Eyre and Spottiswoode (Publishers), Limited. 8½" × 5½", pp. 138. Price 10s. 6d.

One of "The Practitioner Handbooks" by fifteen contributors.

"Surgery of the Eye", by Meyer Wiener, M.D. Second Edition; 1949. New York: Grune and Stratton. 9" × 5¾", pp. 442, with 425 illustrations. Price $12.00.

Designed to be a handy atlas for the practising ophthalmologist and student of ophthalmology on the surgical correction of ocular defects and diseases.

"Some Aspects of Hostility in Young Children", by Anneliese Friedsam Korner; 1949. New York: Grune and Stratton. 8½" × 5½", pp. 112. Price $3.50.

An attempt to compare "the ways in which a group of pre-school children dealt with their hostility feelings at the level of play and phantasy with the modes which they employed in real-life situations".

"The Achievements of BCG Vaccination", by Gerhard Hertzberg; illustrated by Material at the Tuberculosis Department of the Oslo Public Health Service; 1948. Oslo: I Kommisjon Hos Johan Grundt Tanum Forlag. 10" × 6½", pp. 324.

Based on work carried out in 1947 on 100,000 persons of both sexes and all ages and social strata.

"Medicine", by A. E. Clark-Kennedy, M.D., F.R.C.P.; Volume II: Diagnosis, Prevention and Treatment; 1949. Edinburgh: E. and S. Livingstone, Limited. 9¼" × 6¾", pp. 527. Price: 25s.

A sequel to Volume I which dealt with "The Patient and His Disease".

"The 1948 Year Book of General Therapeutics", edited by Oscar W. Bethea, Ph.M., M.D., F.A.C.P.; 1948. Chicago: The Year Book Publishers, Incorporated. 7" × 4½", pp. 482, with 60 illustrations. Price: $4.25.

One of the "Practical Medicine Series" of Year Books.

The Medical Journal of Australia

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All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

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THE DOCTOR-PATIENT RELATIONSHIP AND ITS PRESERVATION.

THE medical practitioner, probably more than any other type of person in the community, is an individualist. That is to say, he works as an individual for individuals, planning his treatment to suit their individuality. The very nature of his calling makes this inevitable. If man was built of so many parts which were essentially similar, like the parts, the bits and pieces that are turned out on the endless production belt of a motor-car factory, each ready for its appointed job and waiting merely to be assembled next to its proper fellow to do that job, the doctor's task would be different. He would look on men and women as conforming to certain types of chassis, with engines of a horse-power to suit the chassis and so on. It is man's individuality that gives medicine its tremendous fascination. No two persons are alike. No man has his true "double". This is why we have to remember that disease is not an entity—it is not something that lies in wait for a man to seize him and to lay him low, even to bring about his undoing. We speak glibly about a man who has had an attack of pneumonia, about the ravages of influenza and about our fight against tuberculosis. This is a convenient method of expression which sometimes needs to be explained to the non-medical public. The success of a medical practitioner—and in this we refer to his ability to recover the patient of his illness, not to the growth of his banking account—bears a direct relationship to his comprehension of the patient's whole condition and circumstances. This means that he understands the patient as an individual. Alexis Carrel was right when he wrote that disease was a personal event, that it consisted of the individual himself and that there were as many different diseases as there were patients. These considerations are of fundamental importance when we consider what is known as the doctor-patient relationship.

To say that at no period in modern times has it been more necessary to safeguard the doctor-patient relationship than it is at present, is to say something trite. At the same time it is something that must be said. One reason for this is that there are many persons, both medical and non-medical, who are so used to the close relationship that exists between doctor and patient in their own immediate circles, that they cannot imagine any sundering of the tie. As a matter of fact some of these people would find it difficult to put into words what they know about it. Many people think that it is bound up with the obligation on the part of a doctor to keep inviolate any information that he may gain about a patient during the course of his professional work—in other words, that it has to do chiefly with professional secrecy. This is one manifestation of the doctor-patient relationship, which cannot exist without unshakable confidence on one side and absolute reliability on the other. But it is more than a matter of keeping secrets. The existence of a doctor-patient relationship of a special and binding kind implies a knowledge by the doctor of the patient as an individual, a recognition of the "personal event" mentioned by Carrel and of its whole significance. For this two conditions are needed. One is confidence of the patient in the doctor and the other is willingness of the doctor to become the patient's adviser, with, of course, the proviso that he (the doctor) has the knowledge and skill that are necessary. This means that the patient must be free to choose his own doctor and that the doctor should have the right to accept or reject the choice. When the patient has not the right to choose his doctor, as in the practice of many public hospitals, a satisfactory doctor-patient relationship can still exist. When this happens, it is a fortuitous happening; the doctor's reputation as a man with human understanding as well as with skill and knowledge may have preceded his congress with the patient, or he may be one of those fortunate people who inspire immediate confidence in those who lack it. Most doctors do not have to ask themselves whether they would "choose" a patient or not; but every practitioner knows that occasional patients are unpleasant and create discord on what seems to be the slightest provocation. There is no reason, when these people come along, why the doctor should suffer "the pain in the neck". The conclusion is unavoidable that the doctor-patient relationship is of fundamental importance in the present-day practice of medicine. A. C. Ivy, who served as expert medical adviser to the prosecution at the Nürnberg Medical Trial, has stated[1] that, though a reverence for the life of the individual is the basic aspect, the doctor-patient relationship and the free choice of a physician represent the realistic aspects of the moral philosophy of medicine. Accepting this statement—for accept it we must—we must declare that any factor or any proposal that would impair a harmonious doctor-patient relationship must be resisted.

In the course of his article (which deals with Nazi medical war crimes) Ivy makes a point which is of considerable importance. He states his conviction that the system of State medicine in Germany was in part the cause of the deterioration of German medicine and of German medical atrocities. He explains that State medicine was not solely concerned, but that there was also a general decline in moral and religious values. The suggestion that there may be some relation between the general state of society, its moral outlook, and the doctor-patient relationship may appear at first sight to be far-fetched. But this is really not so. It is a matter of the

[1] *The Journal of the American Medical Association*, January 15, 1949.

attitude of the State to the individual, the individual with whom medicine is chiefly concerned. When the State is set up as the ultimate good and the individual is pushed on one side in the process so that some of his rights and privileges are taken from him, those in control will care little whether the individual achieves a satisfying relationship with his doctor or not. Conversely, when the State proposes to arrange medical practice in such a way that the individual will be hard put to it to obtain the personal attention that he desires to obtain from his medical attendant in the way in which he has been used to receiving it, it is time to ask whether the State is not overreaching itself, whether it is not doing so much for the individual that it is depriving him of his rights and responsibilities, in a word, of his freedom. It is time also to ask whether the moral values of public life are not being lost and what is known as the "good life" is becoming a rarity. Ivy states that there is more to medical care than scientific knowledge and skill, and that the environment in which the physician is raised and trained has an effect on him and his activities, regardless of the ethics of medicine. This is not an occasion for a plea that the moral values of the community should be preserved—that is a very large subject which must wait for another occasion. The present is a call to preserve the doctor-patient relationship as it is known to practitioners in every part of this country and to resist any movement, any attempt, to weaken it.

Current Comment.

THE EFFECTIVENESS OF DIGITOXIN.

IN view of the tendency to regard new drugs as necessarily better drugs and new methods as necessarily better than old methods, it is interesting to read a report emanating from the Department of Therapeutics of the New York University College of Medicine and the Third (New York University) Medical Division of the Bellevue Hospital. The late William Osler stated that ability to administer digitalis might be looked on as a reasonable way of estimating a medical practitioner's ability as a physician. In the last thirty years we have passed through several phases. First, small doses of the tincture were given three or four times a day. Then large doses of the tincture were used several times a day. Later there was a vogue for digitalis leaf, and then Nativelle's digitaline in divided doses, Eggleston's massive doses and Gold's single large dose. Sandwiched in among these came the elaboration of digoxin in England, of diginutin in America, and later of digitoxin. The last mentioned has been much praised and has been the subject of many communications to medical journals. Cynics have sometimes said that the ready use of digitoxin was an example of the latest being necessarily the best. It seems advisable to draw attention to recent observations which do not favour digitoxin as the best.

A. C. De Graff, R. C. Batterman and O. A. Rose have discussed the value of digitoxin in congestive heart failure.[1] They gave the drug in divided doses, by the Eggleston method and in a single dose, to different series of patients. Initial doses of 0·4 to 1·6 milligrammes were given when the divided doses were used, subsequent doses being 0·2 to 0·4 milligramme. The therapeutic dose was between 0·9 and 4·8 milligrammes, the average being 2·2 milligrammes. The toxic dose ranged between 1·5 and 9·3 milligrammes. The type of toxicity was in no way different from that usually seen with the whole leaf of *Digitalis purpurea*. The earliest symptoms as a rule were anorexia, nausea and vomiting, but there was no way of predicting which patient would manifest the more serious forms of toxicity, such as abnormal rhythms or heart block. This did not differ in any respect from the toxicity noted with any digitalis preparation. The striking observation, however, was the persistence of toxicity. In several instances toxicity persisted for many days, although the mild toxic symptoms usually subsided within forty-eight to seventy-two hours. When the single dose method was used, 1·2 milligrammes being followed in twenty-four hours by a maintenance dose, only 17% of patients obtained adequate digitalization. With Eggleston's method results were not so satisfactory as those obtained with the divided doses. The conclusion stated by De Graff, Batterman and Rose is that the multiple dose method, in other words the old-fashioned method, is the best method of digitalization, that digitoxin offers no particular advantage over digitalis leaf, and that because of its slow dissipation and the possibility of prolonged and severe toxicity digitoxin is not the most suitable glucoside.

[1] *The Journal of the American Medical Association*, October 16, 1948.

SULPHONAMIDES, PENICILLIN AND PNEUMOCOCCAL PNEUMONIA.

PENICILLIN has very largely superseded the sulphonamides in the treatment of many conditions. For certain types of infection, notably meningococcal meningitis, the sulphonamides seem to have held their own by virtue of their therapeutic efficacy; but in most cases their use is justifiable only on the grounds of ease of administration and this must be balanced against their toxicity and their relative value as therapeutic agents. For pulmonary infections the superiority of penicillin is generally recognized and perhaps needs little emphasis. The subject has, however, been raised from a different viewpoint by I. F. Volini, J. R. Hughes and J. R. Peffer.[1] A comparative study was made of the treatment of a series of patients with pneumococcal pneumonia by means, respectively, of sulphadiazine, penicillin given intramuscularly, penicillin given orally, and a combination of penicillin and sulphadiazine. The total number of patients (239) was rather too small for subdivision into four groups and an attempt at random selection did not produce very homogeneous groups. The results consequently must be interpreted with considerable caution. Penicillin given intramuscularly seems to have been clearly superior in its effects as compared with other forms of treatment, and its value when given orally is probably comparable if allowance is made for a higher incidence of severe illness among patients given penicillin orally than among those in other groups. The point which raises comment in the findings is the apparent poorness of the results obtained with a combination of penicillin and sulphadiazine. Volini and his colleagues seem convinced that this finding is significant. Dosages used were quite comparable, yet they state that with the combined therapy "the mortality rate was higher, the febrile course was prolonged, the incidence of complications was greater, and the duration of treatment was lengthened", despite the fact that over all the severity of the illness in the group was the least of all. They go so far as to suggest an antagonistic action when the two agents are used together. Superficially their figures support these statements. For example, the mortality rates are given as 1·9% with penicillin given intramuscularly, 6·25% with penicillin given orally, 8·9% with sulphadiazine and 10·6% with combined therapy. However, when it is realized that the actual numbers of deaths were 1, 3, 8 and 5 respectively, the percentages become rather meaningless and statistical analysis is not necessary to justify the suggestion that fallacies are possible. This view is supported by H. F. Dowling, who contributed to a discussion on the paper. Dowling quoted a very much larger series to support the superiority of penicillin over sulphonamides in the treatment of pneumococcal pneumonia, the mortality rate with penicillin being only half that with sulphonamides in a series of over two

[1] *Diseases of the Chest*, March, 1949.

thousand patients. However, from a series approximately twice as great as that of Volini, Hughes and Peffer, Dowling was unable to find any appreciable difference between the efficacy of penicillin and that of the penicillin-sulphadiazine combination. He questioned the validity of relying on the small series and urged Volini to continue his investigations so that the position might be clarified. This would seem desirable, for the doubt raised is too important to be ignored, and there are other grounds for supporting Volini's contention that the indications for sulphonamide medication can today be reduced to very few. The simplicity of administration of these drugs has sustained their popularity, but their indiscriminate prescription means that their real disadvantages are ignored and the risk is run that sensitization may prevent their use in the few instances in which they are specifically indicated. Their value should be clearly defined.

AUREOMYCIN.

WHEN Selman A. Waksman published in 1947 the second edition of his book "Microbial Antagonisms and Antibiotic Substances" he gave a list of fifty-six antibiotics. In less than twelve months the hundred mark had been reached. Seldom has there been such widespread and concentrated research in different departments of science, all traversing the same field of endeavour, for not only from laboratories of pathology, but from botanical and agricultural institutes, chemical factories and hospitals there emanated articles announcing important conclusions. No wonder that W. S. Tillett in 1948 could choose as title for an editorial "The Antibiotic Age"![1] Quite early in this extensive search for new members of the group the many complexities of the subject obtruded themselves. While some antibiotics are of simple chemical nature, others are decidedly complex, for example streptomycin has been shown to be made up of two quite separate entities. Some organisms produce more than one antibiotic; the same antibiotic may be elaborated by several lowly developed forms of plant life possessing no genetic affinity. The mode of action of these substances on bacteria cannot be described under one single heading—Waksman gives nine possibilities[2]—all we can say is that the primary action is growth-inhibitory. The enthusiasm of the many investigators has not been damped in the least by the early recognition of the fact that the great majority of the antibiotics discovered are of no service in human medicine. The reasons for these failures are many. Quite a large number are general protoplasmic poisons dangerous to the host; others which gave promising results *in vitro* were found to be without action *in vivo* owing to inactivation by body fluids or fixation by plasma proteins; others again had awkward physical properties such as insolubility in water and tissue fluids; others displayed instability of chemical constitution or a marked capacity to produce resistant strains of the bacteria for which they were employed. Hence out of the extended list of discovered and named antibiotics only a very few have found practical application in chemotherapy and these may be given as antibacterial polypeptides, the penicillin group and the streptomycin complex.

In the *Annals of the New York Academy of Sciences* there was published in November, 1948, a series of sixteen papers dealing with aureomycin. This important contribution to antibiotic literature represents the work of forty-three investigators, sixteen of whom are on the staff of the Lederle Laboratories Division, American Cyanamid Company, Pearl River, New York, the remainder being connected with well-known universities, hospitals and medical research institutes. The entirety gives the impression of a fine piece of organized teamwork, for every imaginable aspect of the preparation, the mode of action on every conceivable microbial parasite and the possible human use of aureomycin has been examined. When negative results were obtained these are described with candour such as "no outstanding usefulness for these antibiotics has been demonstrated by our animal investigation against the bacteria studied". Professor Harold Raistrick in a measured critical survey of this American work[1] sums up as follows: "In the treatment of most Gram-positive bacterial infections the supreme position of penicillin remains unchallenged. Streptomycin appears to hold a similar though less exalted position in the treatment of many tubercular infections; but it seems probable that aureomycin may displace streptomycin in the treatment of many Gram-negative infections, particularly of the urinary tract, because of the unquestioned advantage it possesses that bacteria do not become resistant to it *in vivo* as they often do to streptomycin. In the treatment of viral and rickettsial diseases both chloromycetin and aureomycin offer considerable grounds for hope in infections which have so far proved very resistant to chemotherapeutic agents." In a "Current Comment" published recently in this journal the value of aureomycin in enteric infections was reviewed.[2] It is there stated: "Aureomycin has certain advantages; it is highly stable in the dried form, it is active *in vitro* against many bacteria, including cocci and Gram-negative bacilli and some organisms resistant to penicillin and streptomycin and it appears to be clinically effective when given by mouth." It should perhaps be pointed out that a brief account of the physical and chemical properties of aureomycin by R. W. Broshard and eight collaborators will be found in *Science*, Volume CIX, February 25, 1949, at page 199. One may here note *en passant* that a London evening newspaper derived the word not from *Streptomyces aureofaciens* from which this antibiotic was originally obtained, but "because it can be given by the mouth"!

ANTIHISTAMINE DRUGS AND THE COMMON COLD.

SCEPTICISM about cures for the common cold is reinforced when the proposed solution is a fashionable drug, a popular panacea of the moment. Nevertheless the claims made by J. M. Brewster[3] of the effectiveness of antihistamine drugs warrant consideration, albeit with caution. Acting on the suggestion that the initial phase of the common cold was an allergic reaction, he treated a large series of patients apparently in the initial phase with five drugs of the antihistamine type, using as control treatment a combination of codeine sulphate and papaverine hydrochloride—an accepted and common form of treatment in the United States. Brewster's statement is that 19 of 21 patients in whom treatment with the antihistamine drugs was begun within the first hour after onset of symptoms were cured. In 116 (74%) of the patients in whom treatment was begun within six hours of the onset of symptoms a cure was obtained. The effectiveness of the treatment was inversely proportional to the lapse of time following the onset of symptoms before treatment was begun. The control treatment was apparently much less effective. The effectiveness of the drugs was not confined to patients known to be allergic. A sufficient dosage was 50 milligrammes of the selected drug repeated two or three times at intervals of four hours. If the cold was not aborted, continued use of the drug is stated to have had palliative value. This all sounds very attractive, but the great difficulty in diagnosing the common cold in its early stages and the frequency with which what seems to be an early cold will spontaneously abort make assessment of the treatment very difficult. It will need a very large series with thorough control arrangements to determine its efficacy, and it would certainly be unwise to put these powerful drugs into the public hands as a popular prophylactic against self-diagnosed colds. However, the idea is worth following up, not the least attractive aspect of the therapy being Brewster's suggestion that control of sneezing, coughing and profuse nasal discharge should contribute materially to the reduction of spread of infection. We shall wait with interest to learn if others are able to duplicate his results.

[1] *The American Journal of Medicine*, Volume IV, 1948, page 159.
[2] Selman A. Waksman: *Biological Reviews of the Cambridge Philosophical Society*, Volume XXIII, October, 1948, page 452.

[1] *Nature*, January 29, 1949, page 159.
[2] THE MEDICAL JOURNAL OF AUSTRALIA, April 9, 1949, page 502.
[3] *United States Naval Medical Bulletin*, January-February, 1949.

Abstracts from Medical Literature.

PÆDIATRICS.

Streptomycin in the Treatment of Pertussis.

HARRY LEICHENGER AND ALLEN SCHULTZ (*The Journal of Pediatrics*, November, 1948) describe the use of streptomycin in the treatment of pertussis. A small series of cases was divided into three groups. In one, the patients were treated by inhalation of streptomycin, and in one by intramuscular injection of streptomycin; in the third only symptomatic treatment was given. For inhalation, one gramme of streptomycin was dissolved in eight millilitres of normal saline and each three hours one millilitre of the solution was nebulized by a stream of oxygen and administered through an infant-sized "B.L.B." mask. The intramuscular dose of streptomycin was one gramme daily, given in eight equal doses at intervals of three hours. The treatment in each group was continued for one week. Though the number of patients was small, the observers were convinced that the decrease in the number of paroxysms, the lessening of the severity of the paroxysms, the decrease in complications and the clinical impression of trained observers all indicated that streptomycin is an effective therapy, especially when given by the aerosol route, and more extensive trial is warranted.

Angiocardiography.

MERL J. CANSON, THOMAS H. BURFORD, WENDELL G. SCOTT AND JAMES GOODFRIEND (*The Journal of Pediatrics*, November, 1948) describe in brief the technique of angiocardiography and its use in the diagnosis of certain congenital cardiac lesions in children. They state that it is essential to have equipment capable of producing a rapid sequence of radiographic exposures. The tautograph developed by one of the authors makes ten exposures in a period of ten seconds. It is possible to follow the passage of "Diodrast" from the superior *vena cava* throughout the chambers of the heart and the great vessels. The patient is placed in the tautograph, a cannula is tied into the right antecubital vein and a slow intravenous drip administration of saline solution is commenced. A few minims of 75% "Diodrast" are injected through the cannula. If no reaction occurs after several minutes, the final injection is made. Infants aged three months to two years receive 10 to 18 millilitres of "Diodrast"; children aged two to ten years 20 to 30 millilitres; children aged eleven to fifteen years 30 to 40 millilitres. The article is illustrated by X-ray pictures, showing the passage of the opaque medium through a normal heart and great vessels, an example of tricuspid stenosis with nonfunctioning right ventricle, one of persistent *ductus arteriosus*, one of tetralogy of Fallot, and one of Eisenmenger's complex.

T. H. BURFORD AND M. J. CANSON (*The Journal of Pediatrics*, December, 1948) point out that while the intravenous injection of "Diodrast" gives good pictures of the right side of the heart and of the pulmonary arteries, visualization of the left side of the heart and particularly of the aorta is sometimes inadequate. They therefore describe a technique by which "Diodrast" is injected into the left common carotid artery, and so backward into the aorta. Thus adequate visualization of a patent *ductus arteriosus*, a coarctation of the aorta or other anomalies of the aorta is possible. They claim that use of the carotid artery in children is safe, though fraught with some hazard in the adult.

The Aggressive Child.

J. D. W. PEARCE (*The Journal of Mental Science*, July, 1948), while placing the emphasis on the community rather than on the aggressive child, states that the child has three main methods of expressing his aggression. The first is truancy and vagrancy, resulting from really serious frustration, for example, when the school work is either too difficult or too boring. Running away from home is usually an expression of escape from some intolerable situation. To return the child to such an environment without some adjustment is unconstructive and usually results in a repetition or a negative and passively uncooperative child. Secondly, stealing habits nearly always start in childhood and the majority are practised in company. Some have their basis in lack of affection; the majority are reaction character traits or some expression of neurotic behaviour. Many of these children show little anxiety or self-criticism. Their one source of reproach is that they have been caught. The third technique of the aggressive child is in directly aggressive conduct, bullying, damage to property and even murders. The author states that home and the neighbourhood, school and religion, civic and national attitudes do most to mould the child. Customs, laws and regulations have done more to disturb the growing child than ignorance, misunderstanding and inherent frailties. He considers that more good will accrue if attention is directed to uncovering and remedying social conditions which permit or encourage such unproductive aggression than from attempting individual salvage exercises.

The Radiology of Intestinal Obstruction in Children and Infants.

J. H. MIDDLEMISS (*Archives of Disease in Childhood*, December, 1948) discusses the value and difficulties of plain X-ray examination of the abdomen in children and infants suspected of having intestinal obstruction. He points out that radiologically the various parts of the small and large bowel can be recognized. The upper part of the small bowel lies chiefly in the left upper part of the abdomen and shows mucosal folds close together. The middle part of the small bowel lies in the region of the umbilicus and shows wider mucosal folds. The lower part of the small bowel lies mainly in the right flank and pelvis and shows the smooth walls of the ileum devoid of mucosal folds. The caecum and ascending colon lie in the right flank, the transverse colon across the upper part of the abdomen and the descending colon in the left flank; all show the characteristic haustrations or sacculation of the large bowel. Two films are taken: one an antero-posterior projection, with the child supine, and the other a postero-anterior projection, with the child standing or held erect. The radiological signs of small-bowel obstruction are stasis in the small bowel usually with fluid levels, and gaseous distension of the small bowel proximal to the obstruction. Distal to the obstruction there is an absence of gas. The author strongly emphasizes the fact that the demonstration of fluid levels in bowel is not an indication of intestinal obstruction. It merely indicates that at the time of exposure the contents in that part of the bowel are static. It is essential to analyse all gas shadows, to determine the site and distribution of the fluid levels, to assess the degree of distension of the bowel and to establish the fact that gas does not exist in any quantity in the bowel beyond that part in which the fluid levels are present.

Folic Acid in Cœliac Disease.

JOHN DUNCAN HAY (*Archives of Disease in Childhood*, December, 1948) has made a study of the effect of the administration of folic acid to 22 children suffering from cœliac disease. The children were first observed for a period of one or more months while being treated with a diet of low fat and high protein content, liver extract given orally and parenterally and vitamins. Weight gain and the character of the fæces were noted. Then folic acid was given in the dosage of 10 milligrammes or 20 milligrammes daily for one or more months, the former treatment being otherwise unchanged. None of the children were suffering from macrocytic anæmia, but the majority were much underweight. Hay found no convincing evidence of any benefit from folic acid, the hæmoglobin level, the nature of the stools and the body weight showing little change.

Psychoanalysis in Childhood.

SANDOR LORAND (*The American Journal of Psychiatry*, November, 1948) stresses the importance of the developmental history from early childhood with emphasis on the first love attachments, frustrations and reaction to the initial manifestations of the sexual impulse. In the first year the outstanding indications of conflict are feeding problems. In the second year these conflicts are evident in the tense, anxious, dependent and self-centred child. This appears to be a vital year in influencing the control of early drives and impulses and results either in an ability to deal with the environmental demands and the innate drives, or a weak intimidated anxious attitude. Harsh intimidation or no discipline whatsoever will result in inability to cope with the environment or the development of defence measures, which manifest themselves in neurotic symptoms or behaviour problems, such as social or sexual maladjustment, temper tantrums, aggressiveness or sullenness —all acting as protection against the instinctual drives. The progressive adjustment to educational influences depends on the earliest relationship which allows a sufficiently strong ego to be set up before the superego develops. If the reverse happens, childhood developmental periods will be characterized by strong dependency, anxiety, ineffectiveness or aggressiveness and rebellious behaviour. The amount of love, encouragement and compensation

which the child experiences up to the age of five or six years will strengthen the ego; at the same time self-discipline is being taught. The basic organization of the superego is well advanced by the age of five years. In the child emotional conflicts are readily seen in action; the adolescent combines the sensitivity of the child with the adult intelligence. Here there is a tendency in both the child and the parents to retain the earlier interdependent attitude. It is mentioned that behaviour problems may be simple neurotic traits or a psychotic manifestation. Some tension between instinctual drives and the superego is inevitable; the child is always in need of help in acquiring a more independent superego. Insecure parents correspondingly affect their children. The object finally is to prevent further conflicts, the ending of needless frustrations and the provision of modes of gratification for the young both at home and at school.

ORTHOPÆDIC SURGERY.

Bone Lengthening.

F. G. ALLAN (*The Journal of Bone and Joint Surgery*, August, 1948) states that two inches of lengthening may be gained in the femur, and three inches in the tibia and fibula, without complication. More than this may be secured at the risk of temporary external popliteal paresis. Lengthening of the tibia and fibula is more certain and more easy to control than lengthening of the femur. Traction and countertraction through the bone, with complete lateral rigidity, are essential to success. In applying this technique to the femur there is a danger of knee stiffness. The farther from the knee the skeletal traction pins are inserted, the less is the risk. The operation should therefore be planned as high as possible in the shaft of the femur. The most delicate structure, and the one least tolerant of stretching, is the external popliteal nerve. An oblique osteotomy, started by closely spaced drill-holes, is the best. Certain vascular complications experienced by other surgeons are attributable to subperiosteal bone exposure, and to division of the periosteum and fascial structures transversely.

Infections of the Hand.

J. B. LOUDON, J. D. MINIERO AND J. C. SCOTT (*The Journal of Bone and Joint Surgery*, August, 1948) accept the usual classification of infections of the hand, but in addition divided them into four degrees based on the most constant symptoms and signs. They state that the principles of treatment are based upon evacuation of pus and excision of necrotic tissues. With adequate exposure and a bloodless field the necrotic area can be seen clearly. Excision replaces the usual process by which dead tissues are eliminated by discharge. Healing is thereby accelerated. Moreover, the best possible conditions are provided for control of residual infection by the striking and immediate improvement in local blood supply after relief of tension. Immediate or early skin cover is considered the best defence against secondary infection, and it minimizes the amount of scarring. Primary suture is therefore carried out whenever possible, the tissues being protected thereafter from the trauma of movement by immobilization in plaster. When immediate skin cover is not possible, early skin grafting is used, the principle of infrequent dressing and plaster protection being employed meanwhile. Early healing is the key to recovery of function. Nothing but harm can result from attempts to persuade a patient to move a finger in which there is still infection. Penicillin is usual in pre-operative treatment. The authors point out that penicillin and local rest by means of a plaster slab will permit improvement of general condition and control spread of infection, but fail to influence the local lesion, however small, in which death of tissue has already occurred. At operation the main concern is not only to gain free exposure of the lesion, but to retain free blood supply to the skin and underlying tissues, and to secure good functional and cosmetic results, aims best achieved by the use of skin flaps turned back from curved incisions placed in the skin creases, parallel to skin creases, or remote from skin creases. In this way even the most gravely contracted scar never interferes seriously with function. The ideal is to leave no dead skin and to remove no living skin. The skin must be handled gently, the full depth of subcutaneous tissue being mobilized with it. Pus is evacuated. Necrotic tissues, recognized by their colour, are then excised. If there is infection of bone with sequestrum formation the dead bone is removed. A thin layer of penicillin powder is insufflated and the flap is sutured without tension. Thick coverings of penicillin powder are to be avoided as they retard healing. The tourniquet is released only after suture is complete. A dry calico dressing is applied. The affected part only is immobilized in plaster. Elevation and immobilization are continued until swelling has disappeared and the wound is healed—usually within ten days. Sutures are not removed in less than seven days. Gentle use of the digit is encouraged as soon as the wound is healed. Full movements were regained in all the authors' cases by ordinary use of the hand, except in the case of two patients who needed physiotherapy. In the treatment of tendon-sheath infections procedure varies with the degree of infection.

Reflex Sympathetic Dystrophy (Causalgia of the Extremities).

J. W. TOUMEY (*The Journal of Bone and Joint Surgery*, October, 1948) states that reflex sympathetic dystrophy is a disturbance of the sympathetic nervous system, characterized by pain and sympathetic phenomena which may follow major or minor trauma. Its most prominent feature is chronic, continuous, burning pain. Characteristic sympathetic phenomena also appear, the most common of which is vasoconstriction, which causes whiteness or blueness of the affected extremity. Conversely, there may be vasodilatation, with redness of the extremity. Objective signs are coldness, increased sweating, skin colour changes—usually pallor or cyanosis—and swelling of the extremity. In the advanced cases, the hand or foot is puffy, with enlarged, stiff joints not unlike those of rheumatoid arthritis. The skin becomes atrophic, smooth and thin, with loss of wrinkles, and the nails become ridged. X-ray examination of the bones shows generalized or spotty decalcifications, known as trophic osteitis or Sudeck's bone atrophy. The author states that nerve injury and blood vessel injury are notorious causes of reflex dystrophy. It is, however, the vasomotor temperament of the individual, rather than the nature of the trauma or the type of treatment, which tends to produce the sympathetic dystrophy. Local injection of procaine is the key to diagnosis, and this may also effect a cure when used peripherally or to block the sympathetic ganglia. The author advocates procaine block of the appropriate segments of the sympathetic chain. Patients who obtain little or no relief from a block will obtain little or no relief from sympathectomy; the reverse is also true to a lesser extent. Sympathectomy was performed in 75% of the author's cases, relieving the pain in two-thirds of the cases. The author believes that sympathectomy should be performed even when the result of sympathetic block is not satisfactory, if the typical objective sympathetic phenomena are present. The prognosis is better for patients who have not had reflex sympathetic dystrophy for a long period of time. The author states that the importance of active use of the extremity as a valuable means of breaking the reflex must not be forgotten. The underlying principle in preventing the occurrence of reflex sympathetic dystrophy is to treat the trauma so that painless function of the extremity is restored in the quickest possible time.

Arthrodesis of the Ankle Joint.

J. C. ADAMS (*The Journal of Bone and Joint Surgery*, August, 1948) states that the transfibular approach for arthrodesis of the ankle joint has in recent years been adopted as the standard procedure at a number of orthopædic centres. The fibula is exposed subperiosteally in its lower third and divided three to four inches from its lower end. The distal fragment is removed and prepared for use as an onlay graft by splitting off the inner cortex throughout its length. Ligamentous tissues are stripped from the lateral aspect of the lower end of the tibia and the ankle joint is clearly exposed in the lower half of the wound. The articular cartilage of both tibia and talus is then erased down to vascular bone, from the lateral side, with a gouge or osteotome. The bones are trimmed so that when the intervening gap is closed the foot rests in the optimal plantigrade position with a few degrees of equinus. Small spaces remaining between the bone ends are filled with cancellous bone chips. A bed is prepared for the fibular graft by freshening the lateral aspect of the tibia and astragalus. The cancellous aspect of the graft is applied to the graft-bed, bridging the joint space. The graft is secured by three screws, two of which grip the tibia and one the astragalus. Weight-bearing in plaster is encouraged within a few weeks of operation. After twelve weeks, the plaster is removed for clinical and radiographic tests of fusion. Thirty cases have been studied. In 28 there was successful primary fusion in an average period of thirteen weeks. The two cases in which first operation failed could both be explained by errors in technique or after-treatment.

British Medical Association News.

ANNUAL MEETING.

THE annual meeting of the New South Wales Branch of the British Medical Association was held at British Medical Association House, 135 Macquarie Street, Sydney, on March 31, 1949, COLONEL A. M. MCINTOSH, the President, in the chair.

ANNUAL REPORT OF COUNCIL.

On the motion of Dr. H. R. R. Grieve seconded by Dr. R. H. Macdonald the annual report of the Council was received. In moving the adoption of the report Dr. Grieve pointed out that the present was the fortieth year in succession in which Sir Charles Blackburn had been a member of Council. He referred to the soundness of his opinions and to the reliance which the Council placed upon them. He suggested that Sir Charles Blackburn should second the motion. In so doing Sir Charles Blackburn thanked Dr. Grieve for his remarks. The motion was carried. The report is as follows.

The Council presents the following report on the work of the Branch for the year ended March 31, 1949.

Membership.

The membership of the Branch is now 2845, as against 2769 at the date of the last report. The additions have included 131 elections, reelections and resumptions, and 61 removals into the area of the Branch; while the losses have included 15 by resignation, 49 removals out of the area of the Branch, 24 by default in payment of subscription, and 28 by death. The losses by death were as follows: Dr. A. E. Platt, Dr. C. J. Fallon, Dr. W. M. Helsham, Dr. R. V. Graham, Dr. J. Kerr, Dr. V. W. Savage, D.S.O., Dr. C. G. Rice, Dr. W. B. Clipsham, Dr. R. M. Lane, Dr. R. D. Davey, Dr. C. B. Pym, Dr. M. Potiris, Dr. E. L. D. Parry, Dr. R. Beith, Dr. A. J. Park, Dr. W. J. R. Nickson, Dr. J. Z. Huie, Dr. D. Wallace, Dr. G. L. L. Lawson, Dr. Elsie J. Dalyell, O.B.E., Dr. A. C. Platanov, Surgeon Commander W. E. Roberts, Dr. J. M. Gill, Dr. J. A. Parkes, Dr. T. F. Tonkin, Dr. Y. E. Pittar, Dr. A. G. Butler, D.S.O., Dr. C. A. McHardy.

Obituary.

Arthur Graham Butler, D.S.O.

The Branch has suffered by the death on February 27, 1949, of Dr. Arthur Graham Butler, D.S.O. A member of the Association for many years, he was at one time Honorary Secretary and, subsequently, President of the Queensland Branch. He was also Joint Honorary Secretary of the Australasian Medical Congress, 1920. He wrote "The Official History of the Australian Army Medical Services in the War of 1914-18" (Volumes I, II and III). As an appreciation of the valuable services he had rendered to the profession and the nation in compiling this monumental work, the Federal Council in 1943 awarded him the Gold Medal of the British Medical Association in Australia.

Meetings.

Ten ordinary meetings of the Branch (including the annual general meeting) and two extraordinary meetings of the Branch and ten clinical meetings were held. The average attendance was 88. Nine of the ordinary meetings were held in conjunction with meetings of special groups, namely: April 29, with the Oto-Rhino-Laryngological Society of New South Wales (British Medical Association); May 27, with the Section of Neurology, Psychiatry and Neurosurgery; June 24, with the Section of Anæsthesia and the Section of Medicine; July 29, with the Section of Pathology and the Section of Obstetrics and Gynæcology; August 26, with the Section of Urology and the Section of Medicine; September 30, with the Section of Pædiatrics and the Section of Neurology, Psychiatry and Neurosurgery; October 28, with the Orthopædic Group (British Medical Association) and the Section of Medicine; November 25, with the Section of Medicine and the Section of Pathology; December 9, with the Section of Medicine and the Section of Surgery.

The clinical meetings were held at the Rachel Forster Hospital for Women and Children, Royal Alexandra Hospital for Children, Royal Prince Alfred Hospital, Royal North Shore Hospital, Royal Hospital for Women, Lewisham Hospital, Sydney Hospital, Saint Vincent's Hospital, Broughton Hall Psychiatric Clinic and Saint George Hospital.

The business of the meetings included sixteen papers. At an extraordinary general meeting held on November 26, 1948, the policy of the New South Wales Branch in regard to the Commonwealth Government's plans for a national health service was determined following the presentation of a report by Council on this matter. At an extraordinary general meeting held on October 28, 1948, By-Law 4 was amended to provide for increases in subscription rates.

Representatives.

The Branch was represented as follows:

1. Council of the British Medical Association (1946-1949): Dr. Isaac Jones.
2. Representative Body of the British Medical Association (1948-1949): Representative, Dr. G. G. L. Stening.
3. Annual Meeting, British Medical Association, Cambridge, 1948: Delegates, Dr. H. J. Ham and Dr. Willa Nelson.
4. Federal Council of the British Medical Association in Australia: Dr. A. J. Collins, D.S.O., M.C., Dr. H. R. R. Grieve, Dr. W. F. Simmons, Dr. A. J. Murray, O.B.E.
5. Contract Practice Subcommittee of the Federal Council: Dr. H. R. R. Grieve.
6. Australasian Medical Publishing Company, Limited: Dr. W. F. Simmons, Dr. L. F. Dods, M.V.O., Dr. W. L. Calov.
7. New South Wales Post-Graduate Committee in Medicine: Dr. A. C. Thomas, Dr. J. K. Maddox, V.D.
8. Ophthalmic Association, Limited: Dr. Colin C. Ross.
9. The Flying Doctor Service of Australia: Representative, Dr. George Bell, O.B.E.; Deputy Representative, Dr. J. G. Hunter.
10. Council of the Bush Nursing Association. Colonel A. M. McIntosh.
11. Hospitals Contribution Fund of New South Wales: Dr. Hugh Hunter.
12. Saint John Ambulance Association: Colonel A. M. McIntosh.
13. Standards Association of Australia: (i) Institutional Supplies Committee, Dr. S. W. G. Ratcliff; (ii) Sectional Committee on Interior Illumination of Buildings, Dr. N. M. Macindoe; (iii) Committee on Standards of Laboratory Glassware and Volumetric Glassware, Dr. F. S. Hansman; (iv) Committee on Protective Glass for Welding, Dr. N. M. Macindoe; (v) New South Wales Committee on Protective Occupational Clothing, Dr. W. T. Nelson; (vi) Paint and Varnish Subcommittee Number 8, Dr. W. T. Nelson; (vii) New South Wales Committee on Eye Protection, Dr. N. M. Macindoe.
14. Medical Officers' Relief Fund (Federal): Local Committee of Management for New South Wales, Dr. E. H. M. Stephen, Dr. A. J. Murray, O.B.E., Dr. A. J. Collins, D.S.O., M.C.
15. Medical Appointments Advisory Committee (Hospitals Commission of New South Wales): Dr. L. A. Dey.
16. Special Departmental Committee for the Investigation of Maternal Deaths: Dr. E. A. Tivey.
17. Recreation and Leadership Movement: Professor Harvey Sutton.
18. Council of the Royal Society for the Welfare of Mothers and Babies: Sir Robert Wade, Dr. E. H. M. Stephen.
19. New South Wales Medical Board: Dr. J. R. Ryan.
20. Workers' Educational Association: Dr. R. A. M. Allen, M.C.
21. Council of the New South Wales Institute of Hospital Almoners: Dr. R. A. R. Green.
22. Council of Education: Dr. A. J. Collins, D.S.O., M.C.
23. Examining Council of the Society of Laboratory Technicians of Australasia (New South Wales Branch): Dr. F. S. Hansman, Dr. E. F. Thomson.
24. Medical Finance, Limited, Board of Directors: Dr. E. A. Tivey, Dr. A. C. Thomas, Dr. George Bell, O.B.E., Dr. G. C. Halliday.
25. Council of the New South Wales Institute of Dietitians: Dr. H. R. R. Grieve.
26. Coordinating Council for the Physically Handicapped: Dr. R. A. R. Green.
27. Road Safety Council of New South Wales: Colonel A. M. McIntosh.
28. Federal Medical War Relief Fund: Local Committee of Management, Dr. A. J. Collins, D.S.O., M.C., Dr. A. C. Thomas, Dr. A. J. Murray, O.B.E.
29. Road Safety Council of New South Wales: (i) Committee for the Determination of Visual Standards for Motor Drivers, Dr. N. McA. Gregg; (ii) Committee for the Determination of Physical Fitness of Drivers of Motor Vehicles, Dr. J. H. Halliday.
30. Florence Nightingale Memorial Committee of Australia: Dr. B. T. Edye.

31. Australian Tuberculosis Association, New South Wales Division: Coordinating Committee, Dr. W. Cotter B. Harvey.
32. The Committee for Placement of Resident Medical Officers: Colonel A. M. McIntosh.
33. Council of the Australian and New Zealand Association for the Advancement of Science (meeting, January, 1949): Dr. Ethel B. Durie.

Council.

(a) The attendance of members of the Council and of the standing committees was as set out in the accompanying table.

(b) The representatives of the Local Associations of Members appointed on the invitation of the Council to attend the regular quarterly meetings of the Council were as follows: Dr. W. M. Roberts (Blue Mountains), Dr. L. S. Woods (Border), Dr. R. Segal (Canterbury-Bankstown), Dr. G. N. M. Aitkens (Central Western), Dr. R. L. Douglas (Eastern District), Dr. S. G. Nelson (Eastern Suburbs), Dr. F. P. M. Solling (Hunter Valley), Dr. G. F. Elliott (Illawarra Suburbs), Dr. H. S. Oag (Kuring-gai District), Dr. T. S. Douglas (Northern District), Dr. J. R. Ryan (North Eastern), Dr. R. Cuttle (Southern District), Dr. A. L. Castleberg (South Eastern), Dr. C. H. Jaede (South Sydney), Dr. E. S. Stuckey (Warringah District), Dr. R. D. Mulvey, M.C. (Western), Dr. R. F. Back (Western Suburbs).

Library.

Dr. J. Kempson Maddox was appointed to the position of Honorary Librarian.

Visitors to the library	6723
Books lent to members	1302
Journals lent to members	4537
Books added to the library	186
Journals added to the library	13

The Association is pleased to record its appreciation of donations received from the following: the Editor, THE MEDICAL JOURNAL OF AUSTRALIA, Association of American Physicians, Australian Institute of Anatomy, Baker Medical Research Institute, British Empire Cancer Campaign, Commonwealth Acoustic Laboratory, Flying Doctor Service of Australia, International Labour Office, Mayo Clinic, Rochester, National Health and Medical Research Council, Post-Graduate Committee in Medicine in the University of Sydney, Public Health Department, Queensland Institute of Medical Research, School of Public Health and Tropical Medicine, Sydney Hospital, the Royal Australasian College of Physicians, Walter and Eliza Hall Institute of Medical Research, Women's Hospital, Melbourne, Workers' Educational Association, United Kingdom Information Office, United States Information Library, Dr. George Bell, Dr. E. P. Blashki, Dr. K. S. M. Brown, Professor A. N. Burkitt, Dr. F. N. Chenhall, Dr. C. G. Crawford, Dr. H. C. R. Darling, Dr. J. G. Edwards, Dr. E. M. C. Friedlander, Dr. F. B. Halliday, Dr. A. Rose-Innes, Dr. E. H. Hipsley, Dr. C. H. Jaede, Colonel A. M. McIntosh, Dr. J. K. Maddox, Professor C. G. Lambie, Mrs. H. Peet, the late Surgeon Commander W. E. Roberts, Dr. R. S. Steel, Dr. C. H. Swanton, Sir Robert Wade, Dr. R. J. Whiteman, Dr. B. Basil Jones, and the Section of Radiology, the Section of Obstetrics and Gynæcology, the Section of Medicine, the Section of Pathology and the Oto-Rhino-Laryngological Society of New South Wales (British Medical Association).

Affiliated Local Associations of Members.

Blue Mountains (affiliated 1944): *Chairman*, Dr. L. Bamber; *Honorary Secretary*, Dr. N. Larkins. Membership, 24. Four meetings were held.

Border (affiliated 1908): *Chairman*, Dr. R. A. Robertson; *Honorary Secretary*, Dr. F. G. Favaloro.

Brisbane Water District (affiliated 1948): *Chairman*, Dr. J. H. Paul; *Honorary Secretary*, Dr. J. Dowling. Membership, 14. One meeting was held.

Broken Hill (affiliated 1942): *Chairman*, Dr. S. P. Barnett; *Honorary Secretary*, Dr. F. Schlink.

Canterbury-Bankstown (affiliated 1930): *Chairman*, Dr. J. M. Alexander; *Honorary Secretary*, Dr. J. T. St. Leger Moss. Membership, 49. Five meetings were held.

Central Northern (affiliated 1910): *Chairman*, Dr. W. L. Nickson; *Honorary Secretary*, Dr. E. J. Egan. Membership, 78. Five meetings were held.

Central Southern (affiliated 1909): *Honorary Secretary*, Dr. J. P. Lyttle.

Central Western (affiliated 1910): *Chairman*, Dr. C. A. McDermott; *Honorary Secretary*, Dr. K. S. M. Brown. Membership, 57. Three meetings were held.

Eastern District (affiliated 1913): *Chairman*, Dr. M. E. H. Elliott; *Honorary Secretary*, Dr. A. McNeil. Membership, 37. Three meetings were held.

Eastern Suburbs (affiliated 1911): *Chairman*, Dr. A. D. Frost; *Honorary Secretary*, Dr. L. H. McMahon.

Far South Coast and Tablelands (affiliated 1935): *Chairman*, Dr. L. W. Wing; *Honorary Secretary*, Dr. J. F. Ireland. Membership, 15. Two meetings were held.

Hunter Valley (affiliated 1947): *Chairman*, Dr. C. P. Gordon; *Honorary Secretary*, Dr. F. P. M. Solling. Membership, 35. Five meetings were held.

Illawarra Suburbs (affiliated 1913): *Chairman*, Dr. B. Denning; *Honorary Secretary*, Dr. G. W. Ashby. Membership, 72. Five meetings were held.

ATTENDANCE AT COUNCIL AND STANDING COMMITTEE MEETINGS.

	Council.	Committees.				
		Executive and Finance.	Organization and Science.	Medical Politics.	Hospitals.	Ethics.
BELL, GEORGE. Honorary Treasurer	10	9	5	9	2	1
BEVERIDGE, LORNA D.	12	—	5	—	—	—
BLACKBURN, SIR CHARLES	9	—	—	—	—	3
DAWSON, W. S.	12	—	5	—	—	—
DEAKIN, J. E. F.	12	—	—	10	2	—
DOUGLAS, T. S.	12	—	—	—	—	—
EDYE, B. T.	11	—	—	—	—	3
ELLIOTT, G. F.	10	—	—	—	2	—
GRIEVE, H. R. R. Honorary Secretary and Past President	12	7	3	7	2	2
HALLIDAY, G. C.	10	8	—	—	—	—
HAMILTON, MARIE M.	11	—	—	—	2	—
HOWE, G. L.	12	—	—	12	—	—
MACDONALD, R. H.	12	12	—	12	—	—
MCINTOSH, A. M.[1] President	12	11	5	11	2	3
MADDOX, J. K. President-Elect and Honorary Librarian	11	9	5	4	1	2
MURRAY, A. J.	8	11	—	—	—	3
NELSON, T. Y.	11	—	—	10	—	—
RAWLE, K. C. T.	8	—	—	11	2	—
SIMMONS, W. F.	12	11	—	10	—	—
STENING, G. G. L.	3	—	—	—	—	—
THOMAS, A. C.	10	9	—	—	—	3
THOMSON, E. F.	12	—	5	—	—	—
WILLCOCKS, G. C.	6	—	—	—	—	2
WILLIS, H. H.	12	—	—	—	2	—
Meetings held	12	12	5	12	2	3

[1] Full-time military service.

Kuring-gai District (affiliated 1929): *Chairman*, Dr. J. Woolnough; *Honorary Secretary*, Dr. Marjorie B. Granger. Membership, 69. Five meetings were held.

Northern District (affiliated 1911): *Chairman* Dr. R. B. Lynch; *Honorary Secretary*, Dr. R. J. Jackson. Membership, 71. Three meetings were held.

North Eastern (affiliated 1913): *Chairman*, Dr. N. St. Clair Mulhearn; *Honorary Secretary*, Dr. N. E. Brand. Membership, 57. Five meetings were held.

Southern District (affiliated 1909): *Chairman*, Dr. R. M. Glennie Holmes; *Honorary Secretary*, Dr. J. S. Storey. Membership, 39. Four meetings were held.

South Eastern (affiliated 1914): *Chairman*, Dr. J. B. Street; *Honorary Secretary*, Dr. M. C. McKinnon. Membership, 33. Nine meetings were held.

South Sydney (affiliated 1909): *Chairman*, Dr. W. G. English; *Honorary Secretary*, Dr. C. H. Jaede. Membership, 36. Four meetings were held.

Warringah District (affiliated 1929): *Chairman*, Dr. G. M. B. Hales; *Honorary Secretary*, Dr. E. L. Davis. Membership, 130. Four meetings were held.

Western (affiliated 1908): *Chairman*, Dr. G. B. Downes; *Honorary Secretary*, Dr. S. R. Dawes. Membership, 93. Three meetings were held.

Western Suburbs (affiliated 1908): *Chairman*, Dr. C. W. Coombe; *Honorary Secretary*, Dr. S. Lackey. Membership, 135. Six meetings were held.

Permission was given in the latter part of the year to the formation of the Brisbane Water District Medical Association. Its area, which was formerly a part of the Central Northern Medical Association, includes the Shires of Gosford and Wyong.

Federation of Metropolitan Local Associations.

The approval of Council was given to the formation of the Federation of Metropolitan Local Associations.

Annual Meeting of Delegates.

The thirty-fifth annual meeting of delegates of the affiliated local associations of members with the Council was held on Friday, October 1, 1948.

The delegates present at the meeting were as follows: Blue Mountains, Dr. W. M. Roberts; Border, Dr. L. S. Woods; Broken Hill, Dr. J. B. Wilson; Central Southern, Dr. J. P. Lyttle; Central Northern, Dr. E. J. Egan; Central Western, Dr. G. N. M. Aitkens; Eastern Suburbs, Dr. C. M. Burns; Eastern District, Dr. A. McNeil; Far South Coast and Tablelands, Dr. L. W. Wing; Hunter Valley, Dr. F. P. M. Solling; Illawarra Suburbs, Dr. G. W. Ashby; Kuring-gai District, Dr. H. S. Oag; Northern District, Dr. R. J. Jackson; North Eastern, Dr. J. L. Roberts; Southern District, Dr. Weeks White; South Sydney, Dr. C. H. Jaede; Warringah District, Dr. E. S. Stuckey; Western, Dr. R. D. Mulvey, M.C; Western Suburbs, Dr. R. F. Back.

Special Groups for the Study of Special Branches of Medical Knowledge.

Allergy (inaugurated 1947): *Chairman*, Dr. R. Steel; *Honorary Secretary*, Dr. B. Riley. Membership, 9. Four meetings were held.

Anæsthesia (inaugurated 1934): *Chairman*, Dr. A. D. Morgan; *Honorary Secretary*, Dr. L. T. Shea. Membership, 32. Six meetings were held, one in conjunction with a meeting of the Branch.

Medicine (inaugurated 1924): *Chairman*, Dr. K. B. Noad; *Honorary Secretary*, Dr. S. G. Nelson. Membership, 96. Six meetings were held, five in conjunction with meetings of the Branch.

Neurology, Psychiatry and Neurosurgery (inaugurated 1924): *Chairman*, Dr. D. W. Arnott; *Honorary Secretary*, Dr. S. G. Sandes. Membership, 54. Six meetings were held, two in conjunction with meetings of the Branch.

Obstetrics and Gynæcology (inaugurated 1925): *Honorary Secretary*, Dr. F. N. Chenhall.

Orthopædic Group (British Medical Association) (inaugurated 1923): *Chairman*, Dr. A. Roberts; *Honorary Secretary*, Dr. C. C. McKellar. Membership, 18. Five meetings were held, one in conjunction with a meeting of the Branch.

Oto-Rhino-Laryngological Society of New South Wales (inaugurated 1924): *Chairman*, Dr. R. H. Bettington; *Honorary Secretary*, Dr. V. G. Bulteau. Membership, 44. Six meetings were held, one in conjunction with a meeting of the Branch.

Pædiatrics (inaugurated 1921): *Chairman*, Dr. E. H. M. Stephen; *Honorary Secretary*, Dr. S. E. L. Stening. Membership, 64. Four meetings were held, one in conjunction with a meeting of the Branch.

Pathology (inaugurated 1924): *Chairman*, Dr. E. F. Thomson; *Honorary Secretary*, Dr. G. V. Rudd. Membership, 70. Seven meetings were held, two in conjunction with meetings of the Branch.

Radiology (inaugurated 1926): *Chairman*, Dr. B. P. Anderson Stuart; *Honorary Secretary*, Dr. E. W. Frecker. Five meetings were held.

Resident Medical Officers' Special Group (inaugurated 1945): *Honorary Secretary*, Dr. R. V. MacFadzean.

Sociological Medicine (inaugurated 1944): *Chairman*, Dr. B. Williams; *Honorary Secretary*, Dr. L. S. Wallman. Membership, 13. Three meetings were held.

Surgery (inaugurated 1925).

Urology (inaugurated 1940): *Chairman*, Dr. K. Kirkland; *Honorary Secretary*, Dr. H. G. Cummine. Membership, 12. Two meetings were held, one in conjunction with a meeting of the Branch.

British Medical Association Lectures.

Lectures were arranged as follows:

Eastern District Medical Association, Kempsey, March 26, 1949, Dr. A. C. Telfer, (i) "Cystitis and Lower Urinary Tract Infection", (ii) "Recent Studies in (*a*) Genito-Urinary Tuberculosis, (*b*) Streptomycin, (*c*) Anuria".

Northern District Medical Association, Inverell, December 5, 1948, Dr. Kathleen Winning, "Artificial Feeding of Infants".

By-Laws.

On October 28, 1948, By-Law 4 relating to subscriptions was amended to provide for the full rate of subscription being increased from seven guineas to eight guineas, and in the case of permanent whole-time members of the public service of the Commonwealth of Australia (including the defence services) or of the State of New South Wales (including the New South Wales Government Railways and the University of Sydney) and whole-time members of the staff of a public hospital, from five guineas to six guineas.

The Federal Council of the British Medical Association in Australia.

Resignation of Sir Henry Newland.

Early in the year Sir Henry Newland informed the South Australian Branch of his resignation as one of its representatives on the Federal Council. This resignation carried with it his resignation as President of the Federal Council.

Sir Henry Newland had held the office of President continuously since the inception of the Federal Council in 1933, prior to which he had been President of the Federal Committee. His retirement will be a great loss not only to the Federal Council but to the profession as a whole.

Meetings.

The Federal Council of the British Medical Association in Australia met in Sydney on May 15 and 16, 1948; Perth, August 12, 13, 14, 15 and 20, 1948; Sydney, December 11, 12 and 13, 1948; and Melbourne, March 1, 2, 3 and 4, 1949.

At these meetings the Branch was represented by Dr. A. J. Collins, Dr. H. R. R. Grieve, Dr. W. F. Simmons and Dr. A. J. Murray, excepting that at the meeting in Perth Dr. A. C. Thomas acted as substitute for Dr. A. J. Murray.

Friendly Society Contract Practice.

Common Form of Agreement.

Agreement has been reached between the Council and the Friendly Societies Association of New South Wales to amend Clause 7(*a*) of the Common Form of Agreement to provide that the medical officer shall not be required to supply medicine except in isolated areas where there is no practising chemist.

Australian Natives Association.

The Council has agreed to the provision of medical services on a contract basis under the terms and conditions of the Common Form of Agreement to members of the Australian Natives Association in New South Wales.

National Health Service.

The Commonwealth Government's proposals for a national health service have received considerable attention throughout the year.

An extraordinary general meeting of the Association, which was attended by approximately 350 members, was held in the Robert H. Todd Assembly Hall on November 26, 1948. At this meeting the policy of the New South Wales Branch was determined and was forwarded to the Federal Council.

Prior to the extraordinary general meeting, meetings of Local Associations were held throughout both country and metropolitan areas, these meetings being addressed by the officers and members of Council.

British Commonwealth Medical Conference.

Dr. A. J. Collins, Vice-President, and Dr. Mervyn Archdall, Editor, THE MEDICAL JOURNAL OF AUSTRALIA, with Dr. Athol F. Quayle, a member of the Queensland Branch, represented the Federal Council of the British Medical Association in Australia at the inaugural meeting of the British Commonwealth Medical Conference held in London on September 15 and 16, 1948.

Empire Medical Advisory Bureau.

The thanks of the profession are due to the Council of the Parent Body for its action in establishing the Empire Medical Bureau for the purpose of welcoming and providing a personal advisory service to practitioners visiting the United Kingdom, particularly those from the Dominions and Colonies.

The Bureau will give advice on post-graduate educational facilities and on the courses of study necessary for higher qualifications and will supply a wide range of information concerning food and clothes rationing, petrol allowances, custom duties, facilities for sport, travel, exhibitions, theatres *et cetera*.

Help will also be given in the problem of finding accommodation. Letters of introduction to the Director of the Bureau will be given to members who intend visiting Great Britain.

World Medical Association.

Dr. A. J. Collins, Vice-President, and Dr. Mervyn Archdall, Editor, THE MEDICAL JOURNAL OF AUSTRALIA, represented the Federal Council of the British Medical Association in Australia at the Second Annual Meeting of the World Medical Association held at Geneva on September 8, 9, 10 and 11, 1948.

Department of Medical Sociology and Research.

The department has continued its work in providing information for the Press on health and medical subjects and preparing broadcast talks, including news commentaries, for delivery by the Spokesman of the Association over the national stations.

Some 170 talks were given during the year, on a wide range of subjects, in the Australian Broadcasting Commission's programmes of "Women's Magazine", "For Business Girls" and "Kitchen Front". Some of the subjects have been suggested by listeners, for instance, squint and stammering in children; and questions are submitted for answer by the Spokesman. Writing on December 17 last, the Australian Broadcasting Commission's Director of Talks commented: "Judging by correspondence, the talks have created a great deal of interest and have been most useful to listeners."

The talks cover a variety of health and medical subjects, care and guidance of children, nutritional principles and simple discussion of recent research in nutrition.

Subsidized Practices.

The Council has made representations to the Minister for Health to have the remuneration substantially increased in those practices in sparsely populated areas in which medical practitioners are providing full-time medical services on a subsidized basis.

Fees Payable to Legally Qualified Medical Practitioners for Services Rendered on Behalf of the Government on Request.

The fees payable for services rendered on behalf of the Government on request are determined by regulations promulgated on September 9, 1909. In view of their present inadequacy the Council has made representations to the Minister for Health to have them increased.

Government Medical Officers.

The following recommendations were made by Council to the Minister for Health in regard to the appointment of government medical officers:

1. That where the appointment of a government medical officer is to be made in any district, applications be called for publicly from those desiring to hold such appointment.
2. That special consideration be given to the applicants in possession of qualifications as pathologists and with medico-legal experience.
3. That the qualifications being equal, preference be given to ex-service doctors.
4. That where a case occurs requiring the application of special pathological and/or medico-legal knowledge by the government medical officer and he does not possess those special qualifications, the Health Department should make available the services of a medical officer from a panel of those possessing the requisite qualifications who would be willing to act in such case.

With regard to recommendation 1, the Minister would not agree to appointments being advertised. As far as recommendations 2 and 4 were concerned, he stated that the government medical officer (Sydney) was available, when necessary, for consultation.

Lunacy Act.

In view of difficulties which have confronted medical practitioners in the admission to the Reception House of patients in respect of whom certificates in the form of Schedule 2A have been issued, representations were made to the Minister for Health to have the *Lunacy Act* amended to overcome these difficulties. Representations were also made for an amendment of the Act in regard to the power of medical superintendents of mental hospitals in the matter of operative procedures on patients under their care.

Workers' Compensation Act.

Schedule of Fees.

Following conferences with representatives of the Associated Licensed Insurers, the Government Insurance Office of New South Wales and the Non-Tariff Association of Australia, an agreement was reached for the introduction of a new schedule of fees, Schedule "F", to replace Schedule "E". The schedule came into operation on February 1, 1949.

The Committee for Placement of Resident Medical Officers.

On October 7, 1948, representatives of the British Medical Association, New South Wales Branch, and the New South Wales Post-Graduate Committee in Medicine interviewed the Honourable C. A. Kelly, Minister for Health, and submitted to him the difficulties which would be experienced in finding vacancies for resident medical officers in the years 1951, 1952 and 1953, as a result of the large number of students who would be graduating.

Following the conference, the Minister decided to appoint a committee to be known as "The Committee for the Placement of Resident Medical Officers" to consider the problem. The committee will consist of a representative of each of the following bodies: (i) Faculty of Medicine, University of Sydney, (ii) New South Wales Post-Graduate Committee in Medicine, (iii) British Medical Association, New South Wales Branch, (iv) Hospitals Commission of New South Wales.

Colonel A. M. McIntosh has been appointed as the representative of the Association.

Resident Medical Officers' Salaries.

Following representations made by Council, the Hospitals Association of New South Wales agreed to recommend to its constituent hospital members that they should apply cost of living adjustments brought about by variations in the basic wage to the salaries of their resident medical staffs.

British Medical Association Food Parcels Fund.

The Council wishes to express appreciation to members for the generous support which they have given to the Food Parcels Fund throughout the year.

The excellent response has enabled the Association to maintain a continual flow of parcels to the beneficiaries of the Royal Medical Benevolent Fund.

The total amount subscribed since the inception of the fund to February 28, 1949, is £1310 7s. 6d.

Supply and Delivery of Milk.

With a view to better safeguarding the health of the public, the Council made representations to the Department of Health that the delivery of milk should be made in metal-sealed bottles with the date of sealing stamped on the seal.

The Department replied that, whilst it regarded the bottling of milk with favour, it would not be practicable to require that all milk for sale be bottled, and that, apart from the fact that the distributors have not the necessary equipment and that in present circumstances a considerable time would elapse before it could be obtained, the com-

pulsory bottling of milk would add to the cost to the consumer.

With regard to the stamping of the date of sealing on the seal, this would necessitate the installation of equipment which could not be obtained at present, and, in any event, would not be an indication of the age of the milk.

The Department referred to the standard for milk required under the *Pure Foods Act*, 1908-1944, and advised that close supervision over delivery is exercised by officers of the Department, appropriate action being taken against offenders when breaches occur.

Wrapping of Bread.

Representations were made by Council to the Department of Public Health to the effect that, as the present method of delivery of bread leaves a good deal to be desired from the point of view of hygiene, the wrapping of bread should be made compulsory. The Department in its reply, whilst agreeing that the wrapping of bread had much to commend it and that it would be an improvement in certain respects, stated that under existing legislation it cannot be enforced. The Department also referred to certain difficulties in the matter and advised that constant supervision over the delivery of bread was exercised by its officers, appropriate action being taken in the case of flagrant breaches of the regulations.

British Medical Agency of New South Wales, Limited.

The annual general meeting of the British Medical Agency of New South Wales, Limited, was held on October 1, 1948. Dr. George Bell, who was in the chair, stated that the directors had pleasure in reporting that the activities of the company had again resulted in a profit. The directors looked forward to the continued support of their own agency by members of the profession.

Medical Finance, Limited.

The annual general meeting of Medical Finance, Limited, was held on October 5, 1948. The chairman, Dr. George Bell, presented the report of the directors for the year ended June 30, 1948. The report showed that a small profit had again been made for the year. Whilst more attractive rates for borrowers are offered elsewhere, the demand for the company's funds must continue on a limited basis.

Premises Revenue Account.

The Premises Revenue Account disclosed a net surplus of £2332 as against a net surplus of £1574 for the year ended December 31, 1947, thus showing an increase of £758 in the net surplus revenue earned. This increase is accounted for by a net decrease in expenditure of £586 and a net increase in income of £172.

The percentages of rent revenue, expenses and depreciation and the percentages of net surplus for the year to the capital value of the land and building (British Medical Association House) as shown by the books at December 31, 1948, namely, £147,248, with the previous year's percentages in parentheses, are as follows:

Rent Revenue (including amount charged for British Medical Association Branch offices *et cetera*)		12·4%	(12·0%)
Sundry Expenses, Interest and Provision for Painting Building	8·9%		(9·2%)
Depreciation of Building	2·0%	10·9%	(1·8%)
Net Surplus for Year		1·5%	1·0%

NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION.

Balance Sheet as at December 31, 1948.

	£ s. d.	£ s. d.
FIXED LIABILITIES.		
Debentures—		
63—4% Series "A" at £10 each	630 0 0	
359—4·65% Series "B" at £50 each	17,950 0 0	
211—4·65% Series "C" at 10 each	2,110 0 0	
	20,690 0 0	
Less Amount Unpaid	54 0 0	
	20,636 0 0	
Australian Mutual Provident Society (secured by Mortgage over Property, B.M.A. House)	45,000 0 0	
General Reserve Fund (used in the business)	1,250 0 0	
		66,886 0 0
CURRENT LIABILITIES.		
Sundry Creditors	462 2 10	
Interest Accrued on Mortgage	159 7 6	
Deposit at Call	700 0 0	
		1,321 10 4
OTHER CREDIT BALANCES.		
Subscriptions Paid in Advance	68 5 10	
Provision for Taxation	2,882 1 0	
Provision for Painting of Building	1,871 0 0	
		4,821 6 10
ACCUMULATED FUNDS.		
Balance at December 31, 1947	88,200 8 2	
Add Surplus for Year ended December 31, 1948—		
Premises Account £2,332 6 9		
Branch Account £620 6 5		
	2,952 13 2	
		91,153 1 4
		£164,181 18 6

	£ s. d.	£ s. d.
FIXED ASSETS.		
Land and Building—B.M.A. House—at Cost *less* Depreciation on Building	147,248 11 3	
Library—at Valuation *less* Depreciation	3,263 10 11	
Office Furniture and Equipment—at Valuation *less* Depreciation	785 18 2	
Debentures—Australasian Medical Publishing Company, Limited (Face Value)	2,100 0 0	
Deposit on Debentures—Australasian Medical Publishing Company, Limited	309 11 4	
Commonwealth Treasury Bonds (Face Value)	7,000 0 0	
		160,707 11 8
FLOATING ASSETS.		
Sundry Debtors (after making provision for Doubtful Debts)—Sundry Tenants, Rent *et cetera*	1,463 10 6	
Cash on Hand	24 8 10	
Commercial Banking Company of Sydney, Limited—Premises and Branch Current Accounts	1,118 1 0	
		2,606 0 4
OTHER DEBIT BALANCES.		
Prepaid Insurance, Rates *et cetera*		868 6 6
		£164,181 18 6

Sydney, March 2, 1949.

A. M. McINTOSH, President.
GEORGE BELL, Honorary Treasurer.
ROBT. J. STIFFE, Financial Secretary.

We have examined the foregoing Balance Sheet with the Books of Account of the New South Wales Branch of the British Medical Association, and, having obtained all the information and explanations we have required, we are of the opinion that such Balance Sheet is properly drawn up so as to exhibit a true and correct view of the state of the Company's affairs according to the best of our information and the explanations given to us and as shown by the Books of the Company. In our opinion the Register of Members and other records which the Company is required to keep by the New South Wales Companies Act, 1936, or by its Articles have been properly kept.

London Bank Chambers,
18-20 Martin Place,
Sydney.

F. W. DUESBURY & Co.,
Chartered Accountants (Aust.).

BRANCH ACCOUNT.

Income and Expenditure Account for the Year ended December 31, 1948.

1948.	£ s. d.	£ s. d.	1948.	£ s. d.	£ s. d.
To Salaries	5,512 3 7		By Subscriptions Received—		
„ Rent—Offices *et cetera*	1,000 0 0		1948	16,302 14 6	
„ Printing and Stationery	1,074 8 10		1947	378 6 0	
„ Stamps and Telegrams	606 13 6		Previous Years	4 19 9	
„ Telephone	175 19 8				16,686 0 3
„ Code Address	2 4 6		*Less* Proportion due to—British Medical Association	3584 19 4	
„ Travelling Expenses	270 10 4		THE MEDICAL JOURNAL OF AUSTRALIA	1,719 3 11	
„ Insurance	7 11 0				5,304 3 3
„ Exchange and Bank Charges	10 2 10				11,381 17 0
„ Refreshments—Meetings	32 17 6		„ Interest	262 7 0	
„ Newspapers	10 11 10		„ Rent Assembly Hall	126 15 0	
„ Sundry Petty Expenses	57 11 11		„ Broadcasting Fees	466 4 0	
„ Tea Money	63 9 2		„ Sales C.F.A. *et cetera*	204 2 1	
„ Federal Council	2,040 15 0		„ Refund Expenses, Federal Council	96 13 9	
„ Legal Expenses	49 14 0				1,156 1 10
„ Repairs—Furniture *et cetera*	35 0 4				
„ Medical Benefits Fund	10 6 9				
„ Pay Roll Tax	125 2 11				
		11,085 3 8			
„ Depreciation—					
Library	294 4 6				
Office Furniture and Equipment	69 3 6				
		363 8 0			
„ Staff Superannuation Fund		469 0 9			
„ Balance being Surplus for the Year ended December 31, 1948, transferred to Accumulated Funds Account		620 6 5			
		£12,537 18 10			£12,537 18 10

Financial Statement.

The Council has pleasure in presenting to members the balance sheet and accounts in respect of the financial year which terminated on December 31, 1948.

The net surplus of revenue over expenditure for the year amounted to £2952 13s. 2d., after making provision for all known expenditure.

The sum of £3171 18s. 2d. has been written off for depreciation of the building (British Medical Association House), plant, office furniture and equipment and the library.

The sum of £200 has been provided out of the current year's revenue to create a reserve for painting the exterior of the building. This amount, for the time being, is used in the business of the Association.

A. M. McINTOSH,
President.

Dr. George Bell moved that the balance sheet of the Branch and the income and expenditure account of the Branch and of the premises should be received. The motion was seconded by Dr. W. F. Simmons. Dr. Simmons also seconded Dr. Bell's motion that the statements be adopted. Both motions were carried.

ELECTION OF OFFICE BEARERS.

Colonel A. M. McIntosh announced that the following had been elected members of the Council for the ensuing year:

Elected by the General Body of Members.—Dr. George Bell, Dr. L. D. Beveridge, Sir Charles Blackburn, Dr. W. S. Dawson, Dr. J. E. F. Deakin, Dr. B. T. Edye, Dr. H. R. R. Grieve, Dr. G. C. Halliday, Dr. H. R. Macdonald, Dr. F. A. Maguire, Dr. A. J. Murray, Dr. T. Y. Nelson, Dr. W. F. Simmons, Dr. A. C. Thomas, Dr. E. F. Thomson, Dr. G. C. Willcocks.

Elected as Representing Women Members.—Dr. Marie M. Hamilton.

Elected as Representing the Public (Government) Medical Service.—Dr. H. H. Willis.

Elected as Representing Country Local Associations.—Dr. T. S. Douglas, Dr. K. C. T. Rawle.

Elected as Representing Metropolitan Local Associations.—Dr. G. F. Elliott, Dr. G. F. Howe.

Messrs. F. W. Dueshury and Company were appointed auditors for the ensuing year.

ELECTION OF REPRESENTATIVE AND DEPUTY REPRESENTATIVE AT THE ANNUAL (1949) REPRESENTATIVE MEETING OF THE BRITISH MEDICAL ASSOCIATION.

On the motion of Dr. A. C. Thomas, seconded by Dr. E. F. Thomson, Dr. G. C. Halliday was appointed representative to attend the Annual Representative Meeting of the British Medical Association (1949) at Harrogate. The appointment of a deputy representative was left in the hands of the Council.

APPOINTMENT OF TWO DELEGATES TO ATTEND THE ANNUAL MEETING (1949) OF THE BRITISH MEDICAL ASSOCIATION AT HARROGATE.

It was resolved that the appointment of two delegates to attend the anual meeting (1949) of the British Medical Association at Harrogate should be left in the hands of the Council.

INCOMING PRESIDENT'S ADDRESS.

Dr. J. Kempson Maddox delivered his address (see page 669). At the conclusion of the address Dr. A. J. Collins moved a vote of thanks to Dr. Maddox for his address. Dr. F. A. Maguire seconded the vote of thanks which was carried by acclamation.

INDUCTION OF PRESIDENT.

Colonel A. M. McIntosh inducted the president for the year 1949-1950 (Dr. J. Kempson Maddox). Dr. Maddox thanked the members for his election.

Medical Societies.

THE MEDICAL SCIENCES CLUB OF SOUTH AUSTRALIA.

A MEETING of the Medical Sciences Club of South Australia was held at the Institute of Medical and Veterinary Science, Adelaide, on April 1, 1949.

The Anatomy and Physiology of Megascolex.

Dr. W. R. Adey read a paper on the anatomy and physiology of the nervous system of a local giant earthworm, *Megascolex*. He said that the dorsal giant fibres of *Megascolex* were so arranged that the median giant fibre was excited by a tactile stimulus to the anterior 55 to 60 segments of the body. Stimulation behind this point excited the lateral giant fibres. The point of change-over was relatively constant and bore no relationship to the total number of segments in the body. A tactile stimulus to any part of the worm's body was uniformly sufficient to produce a giant fibre response. A local contraction temporarily diminished or abolished the excitability by a tactile stimulus. The conduction velocity in the giant fibres reached a maximum of 45 to 55 metres per second. The velocity was

a linear function of fibre size and sheath size, and it varied in different parts of the worm. In the median fibre it was fastest in the middle of the worm, slower posteriorly, and slowest at the anterior end. The lateral fibres conducted progressively more slowly from behind forward. The maximum velocity in the median giant fibre was approximately a linear function of the length of the worm.

Under physiological stimulation an impulse in the giant fibres was conducted equally well in both directions. When they were fatigued by continued electrical stimulation, a type of polarity appeared in the giant fibres at the posterior part of the nerve cord. The lateral fibres ceased to conduct posteriorly and the median fibre would not conduct anteriorly. The sheath of the giant fibres had been estimated in stained sections and in fresh preparations under polarized light. It was a linear function of fibre diameter and approximated 5·3% in the stained sections and 6·0% by polarized light. Shrinkage during processing had also been estimated at 10% of the diameter in the fresh state and was not differential for fibres between 20μ and 75μ.

THE AUSTRALIAN ORTHOPÆDIC ASSOCIATION.

THE annual general meeting of the Australian Orthopædic Association will be held at Sydney on June 1 to 4, 1949. Papers will be presented at meetings to be held at the Robert H. Todd Assembly Hall, British Medical Association House, 135 Macquarie Street, Sydney, on the afternoons of June 1 and 3 at 2 o'clock p.m. on surgical tuberculosis (D. W. L. Parker), fractures about the elbow joint (W. R. Gayton), slipped epiphysis of the femur (E. F. West), tendon transplantation following paralysis (H. Crawford). Clinical meetings will be held at the Royal North Shore Hospital of Sydney on June 2 at 10 o'clock a.m., at Sydney Hospital on June 3 at 2 o'clock p.m., and at Saint Vincent's Hospital on June 4 at 9.30 o'clock a.m.

Post-Graduate Work.

POST-GRADUATE MEDICAL EDUCATION COMMITTEE OF THE UNIVERSITY OF QUEENSLAND.

THE Post-Graduate Medical Education Committee of the University of Queensland announces that the annual post-graduate and refresher course will be held at Brisbane on May 28 to June 3, 1949. The following is the programme.

Saturday, May 28.

Morning.—9.30: Demonstration of orthopædic cases at the Mater Misericordiæ Public Hospital, South Brisbane.

Afternoon.—2: Lecturettes at the Medical School, Herston Road, Valley: (i) "Some Medical Aspects of Chronic Joint Disease", Dr. P. Hannaford Schafer; (ii) "Treatment of Inguinal Hernia", Dr. D. Yeates; (iii) "Recent Advances in Therapy", Dr. O. Hirschfeld; (iv) "Artificial Pneumothorax in the Treatment of Pulmonary Tuberculosis", Dr. K. Hirschfeld.

Evening.—8.15: Lecture at the Medical School: "Sterilization of Surgical Equipment", Dr. R. A. O'Brien.

Sunday, May 29.

Morning.—10: Demonstration of medical and surgical cases at the Brisbane General Hospital.

Monday, May 30.

Morning.—9.30: Lecture at the Medical School: "Modern Transfusion Practice", Dr. E. F. Shaw. 11: Demonstration at the Red Cross Blood Transfusion Centre, 409 Adelaide Street, Brisbane: "Practical Technique in Transfusion", Dr. E. F. Shaw.

Afternoon.—2.15: Demonstration at the Queensland Radium Institute, Brisbane General Hospital, by Dr. A. G. S. Cooper and staff. 4: Clinical demonstration at the Lecture Theatre, General Hospital: "Surgery of the Hand", Dr. A. R. Murray.

Evening.—8.15: Lecture at the Medical School: "Cardiology—Old and New", Dr. T. M. Greenaway.

Tuesday, May 31.

Afternoon.—2.15: Symposium on "Premature Labour and Infantile Prematurity" at the Medical School (Professor G. Shedden Adam, Dr. P. A. Earnshaw). 4: Clinico-pathological conference at the Medical School.

Evening.—8.15: Lecture at the Medical School: "Operations in Certain Abdominal Emergencies", Dr. A. E. Coates.

Wednesday, June 1.

Morning.—10: Clinical demonstration at the Brisbane General Hospital Lecture Theatre (Dr. A. E. Coates).

Afternoon.—2: Demonstration of medical and surgical cases at the Mater Misericordiæ Public Hospital, South Brisbane (the honorary staff).

Thursday, June 2.

Morning.—10.15: Film morning at the Medical School.

Afternoon.—2.15: Lecture demonstration at the Medical School: "The Newer Knowledge of Malaria Parasites", Dr. I. M. Mackerras and Dr. M. J. Mackerras. 4: Lecture at the Medical School: "Lumps in the Breast", Dr. A. E. Coates.

Evening.—8.15: Lecture at the Medical School: "Diagnostic and Therapeutic Progress in Thoracic Disease", Dr. T. M. Greenaway.

Friday, June 3.

Morning.—10: Clinical meeting in pædiatrics at the Mater Misericordiæ Children's Hospital, South Brisbane.

Afternoon.—2.15: Radiological demonstration at the Lecture Theatre, Brisbane General Hospital, Dr. C. Uhr, Dr. K. Uhd. 4: Lecture at the Medical School: "Renal Function", Professor W. V. Macfarlane.

Evening.—8.15: The Bancroft Oration. Sir Henry Newland: "Stages in the Development of the Operative Surgery of Prostatic Obstruction", at the Medical School.

SEMINARS AT ROYAL PRINCE ALFRED HOSPITAL.

THE following seminars will be held at Royal Prince Alfred Hospital, Camperdown, New South Wales. Each seminar commences at 1 p.m. and is followed by a post-mortem demonstration and grand rounds. All members of the medical profession are invited to attend.

May 27, 1949.—Thoracic Section: "Ætiology of Pleural Effusions."

June 3, 1949.—Cardio-Vascular Section: "The Value of X Rays in the Diagnosis of Cardiac Enlargement."

THE MELBOURNE PERMANENT POST-GRADUATE COMMITTEE.

Lectures in Obstetrics and Gynæcology.

UNDER the auspices of the Victorian State Committee of the Royal College of Obstetricians and Gynæcologists the following post-graduate lectures suitable for general practitioners will be held in the Lecture Theatre, Women's Hospital, Swanston Street, Carlton, on alternate Wednesday evenings, commencing June 1, 1949, at 8.30 p.m. June 1: "The Significance of Albuminuria in Pregnancy", Dr. A. M. Hill; June 15: "The Sterile Marriage: A Scheme for its Management", Acting Professor J. W. Johnstone; June 29: "Danger Signs in Prolonged Labour", Dr. R. Rome; July 13: "Breech Presentation: Its Management", Dr. W. M. Lemmon; July 27: "The Significance of the Retroverted Uterus", Dr. L. W. Gleadell; August 10: "Acute Obstetrical Emergencies following Delivery", Dr. D. F. Lawson.

The fee will be 10s. 6d. for each lecture or £2 2s. for the whole course. Enrolments may be made through the Melbourne Permanent Post-Graduate Committee, 426 Albert Street, East Melbourne (JM 1547), or at the Lecture Theatre at the Women's Hospital.

M.R.C.O.G. Examination: Preliminary Notice.

A full-time course has been arranged in Melbourne to commence ten weeks prior to the M.R.C.O.G. examination. At present the date of examination is indefinite, but latest information indicates that this is likely to be October, 1950. The course will comprise approximately sixty lectures in all, and those taking the course will be entitled to attend clinics at the various metropolitan teaching hospitals. The fee will be thirty guineas. More detailed information will be published later.

D.G.O. Part II.

A course suitable for candidates for the D.G.O. Part II will be arranged about July, 1949, by the Victorian State Committee of the Royal College of Obstetricians and Gynæcologists should sufficient candidates apply. Those interested are asked to notify the Melbourne Permanent Post-Graduate Committee.

Special Correspondence.

LONDON LETTER.

FROM OUR SPECIAL REPRESENTATIVE.

"A People Overlaid with Taxes."

THE doctor regards the Budget from two aspects, as a citizen and, since the introduction of National Health Service, as a professional man. The recent financial changes give little relief to him as a citizen, unless he drinks beer or Algerian wine, and the increases in the prices of meat, cheese, butter and margarine will add 4d. to 6d. for each member of his household to his weekly bills. The possible implications to a doctor under the National Health Service will cause even more disquiet, for the Chancellor has instructed the spending departments that no supplementary estimates will be considered by his officials, unless they arise from some major change in policy. The profession has recently affirmed at a Special Representative Meeting that a further £16m. is necessary in order to "implement Spens", the report which lays down the rates of remuneration for general practitioners (THE MEDICAL JOURNAL OF AUSTRALIA, April 9, 1949, page 507); at the present time the General Medical Services Committee is negotiating with the Ministry to this end. In addition the amount allowed for mileage is regarded as inadequate. It is not known what portion, if any, of this £16m. is included in the Ministry's estimates for the coming year, and, if no such provision has been made, whether the application for the extra money would be regarded as being due to a major change in policy. Nobody can accuse the Minister of Health of being biased in favour of the doctors: at times he seems to regard them as necessary nuisances in his scheme. Approval for the £16m. therefore seems somewhat problematic and refusal may lead to a major clash. Telephone costs have gone up steeply in the new Budget, and as these charges are already a sore point with doctors, the present increase is not likely to be well received.

Some aspects of the Budget are wisely and moderately discussed in a recent *British Medical Journal* (April 16, 1949, page 671). It is pointed out that the Chancellor credited the "improved social services" with having a marked effect on infant mortality. The reviewer asks: "Can Sir Stafford Cripps really be ignorant of the fact that the infant mortality curve has fallen steadily and evenly for the past fifty years?" And concludes with the acid comment: "He might just as well and with equal relevance have attributed to the improved social services the increase in juvenile delinquency." The recent alarming growth of this type of crime is causing a good deal of discussion and disquiet.

"His Promises were Mighty."

Regional hospital boards and hospital management committees have been ordered to reduce their estimates for the coming year and are not happy about it, especially as it has been specifically laid down that the results of such cuts are not to react on the patients. One Regional Hospital Board has protested strongly and is to tell the Ministry that the reduction of income, some £221,000, will mean the closing of a number of hospital beds in the area (2000 is the figure mentioned), dismissal of staff, and must be detrimental to the treatment and well-being of the patients. A hospital management committee has taken its first step on the economical path by reducing the number of cleaning staff and boiler men. Details are becoming available as to how the money spent to date has been allocated to the various branches of the service. Approximate figures for the main items in a city area with some 45,000 inhabitants for the period July 5, 1948, to March 31, 1949, were as follows: medical services 18·5%, pharmaceutical costs 19·5%, dental services 35%, and ophthalmic services 22·5%. In considering these figures it should be realized that the city was the centre of a fairly large area and a certain proportion of the dental and ophthalmic costs were for patients coming from outside the city boundaries. The screw has been put on the dental profession already and dentists earning over £4800 a year only receive one-half of their takings over that figure. The ophthalmic service is also under review and from the first of April the fee paid for a sight test has been reduced from £1 11s. 6d. to £1 5s. The original fee was formulated on the assumption that a sight test took 30 minutes, but an inquiry made by the Ministry suggests that 24 minutes is more accurate. A further investigation has been set on foot and the fee finally fixed will be based on this survey. The Minister of Health has not explained how cuts of this nature can be made without detriment to the patients. For once even his undoubted powers of oratory and evasion of the real issue seem at fault.

"Here Did England Help Me."

Sir Hugh Lett and other advocates of the setting up of an Empire Medical Advisory Bureau at British Medical Association House have been more than justified in their belief that such an organization would meet a real need. The Bureau was opened in July, 1948, and from the Annual Report of Council (*British Medical Journal*, April 2, 1949, Supplement page 199) it is learnt that in the first six and a half months of its existence 500 inquirers had made use of the Bureau and about 500 overseas doctors and their wives had attended the monthly "At Homes". Private information shows that this average is being more than maintained in recent months. Inquiries received fall into the following classes: courses of instruction, examinations *et cetera* (30%), accommodation (25%), appointments in hospitals (18%), general information (16%), visits to hospitals *et cetera* (6%) and registration (5%). It must be stressed that though the Bureau is sited in London, its activities cover the whole of the United Kingdom, from reception at the visitor's port of disembarkation to the supplying of train times to take him to his homeward bound ship or plane. One man wrote: "I have had a tremendous time here . . . a great deal of it due to your planning and organization." The Bureau's "Summary of Regulations for Diplomas and Courses of Instruction" is the most comprehensive document of its type in existence and copies have been sent to post-graduate committees, deans of medical schools, and honorary secretaries of all British Medical Association Branches in the Empire. To get the best service from his courteous and efficient staff, the Director asks that the visitor should give as long notice as possible of his intentions, setting out projected time, place, and mode of arrival, whether alone or accompanied, length of stay, and the main objects of his visit. Whilst not essential, a letter of introduction from the local honorary secretary of the visitor's medical association is appreciated.

"The News That's Going Round."

The brevity of cabled news, due to the shortage of newsprint, works sometimes to the advantage of the reader overseas and sometimes to his detriment. As an example of the latter, the first brief account in the daily papers of your struggle regarding the genesis of a National Health Service was read by Australians on this side with interest and sympathy, but with a sense of confusion. The position was greatly clarified by two excellent articles in the *British Medical Journal* of February 12. The bald statement some weeks later of the resignation of Sir Henry Newland from the presidency of the Federal Council gave rise to some perplexity and apprehension; once again the *British Medical Journal* cleared the air by stating that this action was not due in any way to differences between the retiring President and the Council, over whose deliberations he had presided for so long. Many here, interested in Australian medical politics, had come to associate Sir Henry Newland with the Council, in much the same way as they thought of Gog and Magog or of Adelaide and Mount Lofty, the one enhancing the lustre of the other, to the mutual distinction and eminence of both. Confidence was further strengthened by the anouncement that Mr. Victor Hurley was to fill the vacant chair, and the new President's clear statement of policy, as set out in *The Times* of March 22, read well; here brevity was of value as the salient points in dispute were stated clearly and concisely. Mr. Hurley will carry with him in his difficult task the hearty good wishes of his compatriots in the United Kingdom and the same warm respect, which was felt for his predecessor in office, will be extended to him. Another and earlier newspaper item calls for short comment. Some months ago Mr. Chifley was reported as saying that if Australian doctors would not play, prospective medical students would be sent abroad for their training; where such men and women could be trained was not stated. As far as is known here English-speaking medical schools are

strained to the utmost to cope with local applicants, and, as a result, candidates are carefully screened, not only before being accepted, but also during the course; unsatisfactory work or failure to pass examinations within a reasonable time may, and does, lead to permanent relegation. It is not suggested that this latter fate would befall Australian candidates. It does seem, however, that for some years to come it may not be possible to place a body of students sufficiently large to influence a National Health Service. Put shortly, there are good grounds for regarding this project as a Prime Minister's post-prandial pipe dream.

"The Red Light."

The case for better pay for general practitioners (THE MEDICAL JOURNAL OF AUSTRALIA, April 9, 1949, page 507) was sent to the Ministry of Health on March 4, and on April 14, representatives of the General Medical Services Committee went to the Ministry to discuss the proposals put forward. This visit was fruitless in one way, but rather alarming in another. The Ministry are conducting an inquiry as to (*a*) the number of doctors in the National Health Service and (*b*) the total payments made to general practitioners over a period of nine months. Till these figures are available, and middle May was suggested as a likely date, the Ministry felt it would be useless to try to decide whether or not "Spens" is being implemented and so any discussions at present would be futile. An assurance that any adjustments made would be retrospective to July last year was asked for and refused. The real *bombshell* came on the question of arbitration should the two sides fail to agree on this question of pay, as is almost certain. Should any dispute arise in any of the big industries in this country, the matters in dispute are referred in the first instance to a council, known as a Whitley Council, on which both sides are represented. If no agreement is reached in this way, either side can demand compulsory arbitration. Official statements in the past have made it clear that in the National Health Service there would be devised permanent conciliation machinery backed by arbitration to deal with questions such as remuneration (*British Medical Journal*, April 23, 1949, Supplement page 237). The Secretary to the Ministry of Health threw a spanner into the works at the meeting of April 14, when he stated that it must not be assumed without further discussion that participation in the Whitley machinery necessarily involves, in the event of disagreement, the right to resort to arbitration on all subjects. The profession's representatives regard the right to compulsory arbitration on remuneration as essential, and feel further, in the light of previous statements, that the casting of any doubts on this right is a gross breach of faith. So much for the general practitioners and their monetary troubles. The consultants seem to be in a better position. In a recent letter responsible representatives of the Royal College of Physicians refer to "terms of service which are considered by most consultants and specialists to be just and even generous". (*British Medical Journal*, April 30, 1949, page 774.) This statement seems somewhat premature as the considered opinion of the Joint Committee (which represents the consultants and specialists) on the proposed terms of service is not yet available. Will the consultants' testing time come next?

"In Lighter Vein."

The story was told recently of an old lady who went into a fish shop and bought half a pound of whale meat for her supper. As she was putting her parcel into her shopping bag she asked if she "could have the head for the cat".

Correspondence.

AN UNUSUAL SYNDROME.

SIR: May I be allowed space for a further short note on the subject of Bornholm disease, in the light of further information which has become available, and also to thank those practitioners who have provided this information, both through your columns and in letters to me?

A close check on the movements of the first victims of the Bathurst outbreak would seem to indicate that the Migrant Centre was not the initial focus, and now it is clear that the condition has quite frequently been seen in this country previously.

The only addition to the symptom complex described has been evidence of a tendency to relapse, and this I find has been often reported before. Leucocyte counts done on a number of the local cases showed either normal findings or an absolute lymphocytosis, and the few chests we were able to examine radiologically were also normal.

There were only a few instances of spread within family groups, but most of the schools had a number of cases among their boarders. There is evidence that in this outbreak the incubation period varied from five to seven days. The outbreak lasted four weeks, and ceased as suddenly as it began after affecting about one hundred persons.

In conclusion, sir, may I be permitted to suggest to your correspondents that if the name Bornholm is used in connexion with this syndrome it should not I think be in the possessive case, for to the best of my belief the derivation is from an outbreak described on the island of Bornholm, a Danish possession in the Baltic.

Yours, etc.,

142 William Street,
Bathurst,
New South Wales.
May 4, 1949.

R. G. B. CAMERON.

BIOPHYSICS.

SIR: The reviewer of the book on medical physics by Webster and Robertson (THE MEDICAL JOURNAL OF AUSTRALIA, March 26, 1949) has apparently fallen into the error of assuming that students are still admitted to the faculty of medicine of the University of Queensland with little or no knowledge of physics. This is not the case. No student is admitted unless he has passed the senior public (matriculation) examination in physics, or has reached an equivalent standard elsewhere. The lectures, and the text-book which is a record of the lectures, are designed on this basis.

Yours, etc.,

E. S. MEYERS,
Dean, Faculty of Medicine.

The University of Queensland,
Medical School,
Herston Road,
Fortitude Valley, N.1,
Brisbane.
May 3, 1949.

CORONARY OCCLUSION.

SIR: I should be grateful for information of any large series of cases of coronary occlusion in which post-mortem examination revealed thrombosis of the coronary arteries in a large percentage of cases.

Wright Smith, of Melbourne, in 1936 recorded 496 cases in which thrombosis occurred in less than 10%. Newman in 1946 reported 39 fatal cases of coronary occlusion of which 20 showed no thrombosis.

In view of the advocacy of dicumarol and heparin in coronary occlusion, on the assumption that the condition is due to thrombosis, it would be interesting to know if Wright Smith was wrong, and whether any comparable series of cases has been published indicating a contrary finding.

Yours, etc.,

143 Macquarie Street,
Sydney,
May 6, 1949.

G. C. WILLCOCKS.

Naval, Military and Air Force.

APPOINTMENTS.

THE undermentioned appointments, changes *et cetera* have been promulgated in the *Commonwealth of Australia Gazette*, Number 29, of April 28, 1949.

AUSTRALIAN MILITARY FORCES.

Australian Imperial Force.

Australian Army Medical Corps.

To be Temporary Colonels, 8th March, 1942.—VX14845 Lieutenant-Colonel N. M. Eadie, E.D., and VX259 Major (Temporary Lieutenant-Colonel) E. E. Dunlop, O.B.E.

To be Temporary Lieutenant-Colonels, 8th March, 1942.—Captains (Temporary Majors) NX455 A. A. Moon, M.B.E., and NX350 E. L. Corlette, M.B.E.

Interim Army.

Australian Army Medical Corps.

The following officers are appointed from the Reserve of Officers: Captains VX70071 J. M. Lister, 1st December, 1948, VX700079 D. H. Harris, 22nd December, 1948, and VX700088 A. G. G. Carter, M.B.E., 14th January, 1949.

SX34532 Captain (Temporary Major) K. M. Smith relinquishes the temporary rank of Major and is transferred to the Reserve of Officers (Royal Australian Army Medical Corps) (2nd Military District), 25th January, 1949.

The following officers are transferred to the Reserve of Officers (Royal Australian Army Medical Corps): Captains VX700071 J. M. Lister (3rd Military District), 2nd February, 1949, SX700016 J. A. Bonnin (4th Military District), 22nd January, 1949, and VX700025 J. N. Diggle (3rd Military District), 4th February, 1949.

Active Citizen Military Forces.

Eastern Command: Second Military District.

Royal Australian Army Medical Corps (Medical).—2/96519 Major F. D. M. Williams is appointed from the Reserve of Officers with Regimental Seniority in accordance with Army Seniority, and is borne supernumerary to the authorized establishment of Majors, with pay and allowances of Captain (at his own request), 1st May, 1948. 2/126996 Major T. J. Ritchie is appointed from the Reserve of Officers with Regimental Seniority in accordance with Army Seniority, 1st May, 1948. *To be Captain (provisionally), 1st December, 1948.*—2/115677 Miles Tom Havyatt.

Southern Command: Third Military District.

Royal Australian Army Medical Corps (Medical).—3/129123 Lieutenant-Colonel R. S. Smibert, O.B.E., is appointed from the Reserve of Officers with regimental seniority in accordance with Army seniority, is borne supernumerary to the authorized establishment of Lieutenant-Colonels, with pay and allowances of Captain (at his own request), 1st April, 1949. 3/52022 Captain I. D. Wilson is appointed from the Reserve of Officers with regimental seniority in accordance with Army seniority, 1st May, 1948.

Southern Command: Fourth Military District.

Royal Australian Army Medical Corps (Medical): To be Temporary Major, 20th January, 1949.—4/35205 Captain J. M. McPhie.

Western Command: Fifth Military District.

Royal Australian Army Medical Corps (Medical).—5/26397 Honorary Captain W. I. Gordon is appointed from the Reserve of Officers with regimental seniority in accordance with Army seniority, and to be Captain (provisionally), 1st May, 1948. *To be Captain (provisionally), 24th December,* 1948.—5/26398 Henry Sweetman Cohen.

Reserve Citizen Military Forces.

Royal Australian Army Medical Corps.

1st Military District.—The notification respecting Lieutenant J. D. Perry which appeared in Executive Minute No. 188 of 1947, promulgated in *Commonwealth Gazette* No. 241 of 1947, is withdrawn.

3rd Military District.—The resignation of his commission by Captain B. T. Glanville-Hicks is accepted, 18th November, 1948. The resignation of his commission by Honorary Captain R. K. Newing is accepted, 28th February, 1946.

Obituary.

ALDOUS CAMPBELL ARNOLD.

WE are indebted to Dr. Thomas Hamilton for the following account of the late Dr. Aldous Campbell Arnold.

The news of the death of Dr. Aldous Campbell Arnold in the Royal Newcastle Hospital at an early hour on Good Friday morning brought sorrow to his many friends and patients in the Newcastle district, where he had been in professional practice for over thirty years. Born in North Sydney on January 4, 1887, he received his primary education at Mittagong Public School, then at the Sydney Grammar School and the University of Sydney. At the outbreak of war in 1914, he was commissioned as a captain in the Army Medical Corps, afterwards serving in Egypt and Palestine as a medical officer with the Camel Corps, where he attained the rank of major. In 1916, at the village of Chouboura near Cairo, he married Sister Harriett Curtain of the nursing staff of the Second Australian General Hospital. At the termination of hostilities Dr. and Mrs. Arnold proceeded to England, where they had an interesting year while Aldous carried out post-graduate work in dermatology. For the rest of his life he made a keen study of skin diseases, often speaking enthusiastically of his post-graduate year with Sequeira in London.

Returning to Australia, he commenced general practice at Mayfield and was later appointed honorary physician to the Newcastle Hospital, where he had served as a resident medical officer prior to the outbreak of war. In 1937 he gave up general practice almost entirely and devoted himself to specializing in dermatology. In this specialty he soon built up a large practice. In fact during the war years, together with his work on the military medical board, it proved a severe strain on his health.

Aldous Arnold was a colourful character and a man of wide interests. Standing over six feet in height and of fine physique, with a love of discipline, dogs, contract bridge, field sports and outdoor games, he would have made an ideal country squire. A mention to him that quail were in evidence on the foothills of the Barrington Range or in the stubble paddocks round Scone or Dungog was sufficient to excite his interest and set him planning for a shooting trip. He was an active member of the Newcastle Golf Club for many years and a keen fisherman. His more serious interests embraced Saint Andrew's Church of England, Mayfield, where he was a warden for many years, the Dudley Red Cross Home and the Army Medical Corps.

Always forthright in his opinions and fearless in expressing them, he was prominent in discussions at the Medical Board of the Newcastle Hospital and, socially, at the Newcastle Club. To his intimate friends and colleagues who, in an entirely companionable way and for no apparent reason, always addressed him as "Fat", he could be very rude without giving offence or losing their friendship. Such was the way of the man. They knew the true worth that lay underneath his outward mannerisms.

Life for him was ever a robust adventure sweetened by a keen interest in the welfare of his fellow men. Intolerant of bores, he loved the comrades of his strenuous war years. His anecdotes of life in the Camel Corps are legendary.

A foundation member and trustee of one of the Returned Servicemen's League sub-branches in Newcastle, he did many acts of kindness to the members, who always remembered the "Colonel" with respectful admiration. He faced

with equanimity his long illness to its inevitable termination. "I've had a good life", he said, "with no regrets."

His many generous actions will be remembered, especially by the writer, whose children he helped to bring into the world. The graciousness of his home life, in which his good wife played no small part, leaves a host of pleasant memories.

His professional work was always based on sound common sense with a background of wide reading. He contributed occasionally to THE MEDICAL JOURNAL OF AUSTRALIA in pithy style. The sympathy of his colleagues and friends is extended to his widow and to his daughter, Suzanne. Dr. G. P. Arnold, of Windsor, New South Wales, is a brother.

ALICE MARY BARBER.

WE regret to announce the death of Dr. Alice Mary Barber, which occurred on May 8, 1949, at Melbourne.

Medical Prizes.

A PRIZE FOR EX-SERVICEMEN.

RETURNED SERVICEMEN members of the medical profession, attached to the Repatriation Commission, are invited to enter for a monetary prize of £250, offered by the Victorian Branch of the Returned Sailors, Soldiers and Airmen's Imperial League of Australia, to encourage investigation of ailments common to returned men. Work shall be typed (on one side only), left unsigned except for a motto, and lodged with the State Secretary, 4 Collins Street, Melbourne, by April 24, 1950, accompanied by a sealed envelope containing the motto and the entrant's name and address. The League reserves the right to withhold the award of the prize if none of the entries are of sufficiently high standard in the opinion of the selecting committee to warrant the making of an award.

Medical Appointments.

Dr. F. E. T. True has been appointed Official Visitor to the Metropolitan Mental Hospitals, pursuant to Section 74 of the *Mental Hygiene Act*, 1928, of Victoria.

Dr. B. K. Rank has been appointed a Member of the Dental Board, pursuant to Section 38 of the *Medical Act*, 1928, of Victoria.

Dr. J. K. Adey has been appointed a Member of the Medical Board, pursuant to Section 3 of the *Medical Act*, 1928, of Victoria.

Dr. R. H. Hunter has been appointed out-patients registrar at the Royal Adelaide Hospital, Adelaide.

Dr. R. S. Colton has been appointed medical registrar at the Royal Adelaide Hospital, Adelaide.

Nominations and Elections.

THE undermentioned has applied for election as a member of the New South Wales Branch of the British Medical Association:

Noble, Donald Gordon, M.B., B.S., 1948 (Univ. Sydney), 35 Ocean Street, Bondi.

The undermentioned have applied for election as members of the South Australian Branch of the British Medical Association:

Rowe, William Vivian, M.B., B.S., 1948 (Univ. Adelaide), Royal Adelaide Hospital, Adelaide.

Blackburn, Susanne Burton, M.B., B.S., 1948 (Univ. Adelaide), Royal Adelaide Hospital, Adelaide.

Maddern, John Pearce, M.B., B.S., 1948 (Univ. Adelaide), Royal Adelaide Hospital, Adelaide.

The undermentioned have been elected as members of the New South Wales Branch of the British Medical Association:

Anderson, Thomas William, M.B., B.S., 1946 (Univ. Sydney), 17 Grantham Street, Burwood.

Burns, Francis Harding, M.B., B.S., 1948 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

Connolly, John James, M.B., B.S., 1947 (Univ. Sydney), 12 Grace Avenue, Sorlie, French's Forest.

Grant, Alexander Falconer, M.B. B.S., 1948 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

Diary for the Month.

MAY 24.—New South Wales Branch, B.M.A.: Ethics Committee.
MAY 25.—Victorian Branch, B.M.A.: Council Meeting.
MAY 26.—New South Wales Branch, B.M.A.: Branch Meeting.
MAY 27.—Queensland Branch, B.M.A.: Council Meeting.
JUNE 1.—Victorian Branch, B.M.A.: Branch Meeting.
JUNE 1.—Western Australian Branch, B.M.A.: Council Meeting.
JUNE 1.—South Australian Branch, B.M.A.: Council Meeting.
JUNE 2.—New South Wales Branch, B.M.A.: Special Groups Committee.
JUNE 2.—South Australian Branch, B.M.A.: E. C. Stirling Lecture.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135 Macquarie Street, Sydney): Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester United Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phœnix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225 Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178 North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205 Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia. All government appointments with the exception of those of the Department of Public Health.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

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